



Patient name: _____ Date of birth: _____

WEIGHT LOSS PROGRAM

Initial Consultation Questionnaire

OFFICE USE · Initial consultation

Room # _____ Photo ID verified (DL / ID #) _____ Visit date _____
Weight _____ Height _____ BMI _____ Waist _____ BP _____ HR _____ O2 sat _____

Thank you for your interest in our program. Your honest answers help Dr. Vo choose a plan that is safe and right for you. If you are not sure of an answer, your best guess is fine. The consultation fee (\$165) is paid before your appointment is scheduled.

Preferred pharmacy (name and location) _____ How did you hear about the program? _____

1. WEIGHT HISTORY

Current weight (lbs) _____ Weight 6–12 months ago _____ Goal weight _____

Highest adult weight / age _____ Lowest adult weight / age _____ Age when weight gain began _____

What contributed to weight gain? (check all that apply)

- | | | |
|--|--|---|
| ☐ Pregnancy | ☐ Stress | ☐ Job or schedule change |
| ☐ Menopause | ☐ Injury or illness | ☐ Slow, gradual gain |
| ☐ Medication change | ☐ Quitting smoking | ☐ Not sure |

2. PREVIOUS WEIGHT LOSS ATTEMPTS

Diets or programs tried:

- | | | | |
|---|---|--|---------------------------------------|
| ☐ Calorie counting | ☐ Intermittent fasting | ☐ Meal replacement shakes | ☐ Other: _____ |
| ☐ Low-carb / keto | ☐ WW (Weight Watchers) | ☐ Personal trainer | ☐ None |

Weight loss medications taken in the past or now (check all that apply):

- | | | |
|--|---|---|
| ☐ Phentermine (Adipex-P, Lomaira) | ☐ Semaglutide (Wegovy, Ozempic) | ☐ Orlistat (Xenical, Alli) |
| ☐ Phentermine-topiramate (Qsymia) | ☐ Tirzepatide (Zepbound, Mounjaro) | ☐ Compounded injection |
| ☐ Naltrexone-bupropion (Contrave) | ☐ Liraglutide (Saxenda, Victoza) | ☐ Other: _____ |

☐ Never taken weight loss medication

Medication	When	How long	Weight lost	Side effects	Why stopped

Have you had weight loss surgery (gastric sleeve, bypass, band, balloon)? ☐ No ☐ Yes — type and year: _____



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3. EATING HABITS

Meals per day _____ Snacks per day _____ Meals eaten out or fast food per week _____

Who prepares most of your food? ☐ Me, at home ☐ Family member ☐ Mostly eating out

Do you skip breakfast? ☐ Rarely ☐ Sometimes ☐ Often

Do you eat late at night or wake up to eat? ☐ No ☐ Sometimes ☐ Often

Do you eat when stressed, bored or upset? ☐ Rarely ☐ Sometimes ☐ Often

Do you have episodes of eating a large amount while feeling out of control? ☐ No ☐ Yes

Have you ever made yourself vomit, or used laxatives or water pills, to control weight? ☐ No ☐ Yes

4. DRINKS, TOBACCO AND SUBSTANCES

Water per day (glasses, bottles or ounces) _____ Sodas / sweet tea / juice per day _____

Coffee or tea per day (cups) _____ Energy drinks per day _____ Alcoholic drinks per week _____

Tobacco or vaping: ☐ Never ☐ Former ☐ Current

Recreational or street drugs: ☐ Never ☐ Former ☐ Current

5. PHYSICAL ACTIVITY

Current exercise:

☐ None right now

☐ Swimming

☐ Weight training

☐ Walking

☐ Cycling

☐ Sports / classes

☐ Running

☐ Yoga / Pilates

☐ Other: _____

Times per week _____ Minutes per session _____ Anything that limits activity? (pain, injury, breathing) _____

6. SLEEP

Average hours of sleep per night _____ Bedtime / wake time _____

Do you work night shifts or rotating shifts? ☐ No ☐ Yes

Snoring, waking up gasping, or daytime sleepiness? ☐ No ☐ Yes

Diagnosed with sleep apnea? ☐ No ☐ Yes — using CPAP ☐ Yes — not using CPAP

7. MOOD

Over the past 2 weeks, have you often felt down, depressed or hopeless? ☐ No ☐ Yes

Over the past 2 weeks, have you had little interest or pleasure in doing things? ☐ No ☐ Yes

Do you currently take medication for anxiety, depression, ADHD or sleep? ☐ No ☐ Yes

If yes, which ones? _____

Have you ever had thoughts of harming yourself? ☐ No ☐ Yes, in the past ☐ Yes, recently

Some weight loss medications can affect mood. If you are having thoughts of harming yourself now, please tell our staff today, or call or text 988.



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8. MEDICAL CONDITIONS

Check any you have now or have had:

- | | | |
|--|--|--|
| ☐ High blood pressure | ☐ Pancreatitis | ☐ Seizures |
| ☐ Heart attack or heart disease | ☐ Gallbladder disease or gallstones | ☐ Anxiety |
| ☐ Stroke | ☐ Kidney disease | ☐ Depression |
| ☐ Irregular heartbeat or palpitations | ☐ Liver disease / fatty liver | ☐ Bipolar disorder |
| ☐ Heart valve problem | ☐ Acid reflux (GERD) | ☐ Eating disorder (past or present) |
| ☐ High cholesterol | ☐ Gastroparesis (slow stomach) | ☐ Alcohol or drug use problem |
| ☐ Prediabetes | ☐ Sleep apnea | ☐ Joint pain / arthritis |
| ☐ Diabetes: type 1 or type 2 | ☐ PCOS | ☐ Cancer: type _____ |
| ☐ Thyroid problem (over/underactive) | ☐ Glaucoma | |

Has anyone in your family had medullary thyroid cancer or MEN2 (multiple endocrine neoplasia type 2)? ☐ No ☐ Yes
☐ Not sure

Have you had an EKG, heart test or blood work in the past year? ☐ No ☐ Yes — where: _____

Date of your last physical exam and fasting labs _____ Other doctors you see _____

9. MEDICATIONS AND ALLERGIES

☐ I brought my medication list ☐ My medications are up to date in my Athena Family Medicine chart

Current prescriptions, vitamins and supplements, if not listed in your chart _____

Do you take insulin or medication that can cause low blood sugar (such as glipizide)? ☐ No ☐ Yes

Medication allergies and reaction _____

10. WOMEN'S HEALTH

Are you pregnant, trying to become pregnant, or planning a pregnancy in the next year? ☐ No ☐ Yes ☐ Not applicable

Are you breastfeeding? ☐ No ☐ Yes ☐ Not applicable

Birth control method _____ First day of last menstrual period _____

Some weight loss medications can make birth control pills less effective. Dr. Vo will discuss this with you.

11. YOUR GOALS

Why is now the right time for you? _____

What has been the hardest part of losing weight in the past? _____

How ready are you to make changes? (1 = not ready, 10 = very ready) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Do you have support at home? ☐ Yes ☐ Somewhat ☐ No



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WEIGHT LOSS MANAGEMENT AGREEMENT

The purpose of this agreement is to explain how the Athena Family Medicine Weight Loss Program works and what we expect from each other. Signing it does **not** guarantee that you will be prescribed weight loss medication. You must first be evaluated face to face by Dr. Vo and approved as a candidate. This agreement is reviewed and signed by both you and Dr. Vo.

Medication and dose	Prescribed for
	Weight management
	Weight management

Goals of treatment

- To reach and keep a healthier weight, together with changes in eating habits and more physical activity.
- To improve my health and my ability to carry out daily activities, as safely as possible and without dangerous or permanent side effects.

Initials: _____

Program requirements

- Before starting medication, I will complete a physical exam, an EKG and lab work.
- I will complete a **monthly check-in**, in the office or through the Athena patient portal, reporting my **current weight, blood pressure, side effects and any concerns**. My check-in must be reviewed before a refill is sent.
- I must be seen **face to face in the clinic at least once a year**, including an EKG and lab work, to continue in the program.
- The length of treatment will be decided by Dr. Vo.

Program fees (self-pay)

Service	Fee	When it is paid
Initial consultation, and annual face-to-face follow-up visit with Dr. Vo	\$165 per visit	Before the appointment is scheduled
Monthly assessment	Based on the medication prescribed	By invoice, before a refill is sent

- Visit fees can be paid online at athenafamilymedicine.com or by calling our office. After each monthly check-in, staff will send me an invoice. **My refill is sent only after my check-in is reviewed and the invoice is paid.**
- If I cancel at least 24 hours before an appointment, my prepaid visit fee will be refunded, minus Square card processing fees. **With less than 24 hours' notice, or if I miss the appointment, the full \$165 fee is not refunded.** Insurance is not billed for this program; lab work is billed separately by the lab. Fees may change with 30 days' notice.

My responsibilities

- I am responsible for my medication. I will not share, sell or trade it, and I will not take anyone else's medication.
- I will not increase my dose or change how I take my medication without talking with Dr. Vo first.
- Lost, stolen or used-up medication may not be replaced early.
- I will not use other weight loss medications or products (including those bought online, at spas or at other clinics) while in this program unless Dr. Vo approves.
- I will use one pharmacy, and I will tell Dr. Vo about any new medications, health changes, or if I become pregnant, plan a pregnancy or am breastfeeding.
- I understand that some weight loss medications are controlled substances, and their prescriptions are tracked by the Texas Prescription Monitoring Program.

Initials: _____

Risks and results

- Dr. Vo has explained the possible benefits and side effects of my medication. I will report side effects promptly and call 911 or go to the emergency room for serious symptoms.
- Results vary from person to person. No specific amount of weight loss is guaranteed.

Ending this agreement

- If I do not follow this agreement or the clinic's Office Policy, I understand that Dr. Vo will no longer prescribe weight loss medication to me.
- If Dr. Vo decides the medication is causing more harm than benefit, it may be stopped or tapered safely.
- Ending weight loss treatment does not end my primary care at Athena Family Medicine.

Initials: _____



ATHENA FAMILY MEDICINE

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Kevin Vo, MD

Board Certified
Family Medicine

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SIGNATURES

The information on this questionnaire is true and complete to the best of my knowledge. I have read the Weight Loss Management Agreement, or it has been read to me, and I agree to follow it.

Patient name (printed) _____

Patient signature Date

Kevin Vo, MD, signature Date

OFFICE USE ONLY · Physician review

EKG: ☐ Done today ☐ Done within 12 months ☐ Ordered

Labs ordered: ☐ CMP ☐ CBC ☐ Lipid panel ☐ Hemoglobin A1c ☐ TSH ☐ Other: _____

Candidate for medication: ☐ Yes ☐ No ☐ Pending results

Medication and starting dose _____ Start date _____

Starting weight _____ Goal weight _____ Next check-in date _____

Notes _____

Physician signature _____ Date _____