West Annapolis Medical Spa

AT SANDEL DUGGAL PLASTIC SURGERY

PEPTIDE, WELLNESS & MEDICAL WEIGHT MANAGEMENT

UNIVERSAL SCREENING QUESTIONNAIRE

Screening only - not a full medical history, consent, or prescription. Any YES response should be reviewed before treatment.

1. PATIENT BASICS & TREATMENT INTERESTS

Name: _____ DOB: _____ Date: _____

Phone: _____ Email: _____

Height: _____ Weight: _____ Goal weight: _____

Upcoming surgery/procedure/date: _____

_____

Interested in:

- ☐ Recovery Peptide Program (TB-500 + BPC-157)
- ☐ NAD+ + B12 Energy Kit
- ☐ GHK-Cu + Estradiol Skin Cream
- ☐ Semaglutide + Vitamin B6
- ☐ GHK-Cu Skin Cream
- ☐ Tirzepatide + Vitamin B6
- ☐ Not sure / provider recommendation

2. CURRENT MEDICATION / SUPPLEMENT SNAPSHOT

Check any current or recent use:

☐ GLP-1 / weight-loss medication ☐ Insulin or diabetes medication ☐ Blood thinner / aspirin / bleeding-risk medication

☐ Hormone therapy / birth control / estrogen / progesterone / testosterone / tamoxifen / aromatase inhibitor

☐ Steroids / immune-suppressing medication / active cancer treatment ☐ B6 / B12 / NAD+ / peptides / weight-loss supplements

Other medications or supplements: _____

3. PRIORITY SAFETY SCREENING - ANSWER YES OR NO

YES	NO	QUESTION	DETAILS / NOTES
☐	☐	**1.** Pregnant, breastfeeding, or trying to conceive?	
☐	☐	**2.** Surgery, anesthesia/sedation, endoscopy/colonoscopy, or procedure coming up?	
☐	☐	**3.** Currently or recently used semaglutide, tirzepatide, Ozempic, Wegovy, Mounjaro, Zepbound, compounded GLP-1, or appetite medication?	
☐	☐	**4.** Personal or family history of medullary thyroid cancer or MEN2?	
☐	☐	**5.** History of pancreatitis?	
☐	☐	**6.** Gallstones, gallbladder disease, or prior gallbladder removal?	
☐	☐	**7.** Severe reflux, gastroparesis, bowel obstruction, chronic nausea/vomiting, or severe constipation?	
☐	☐	**8.** Diabetes, low blood sugar episodes, or use of insulin/sulfonylurea medication?	
☐	☐	**9.** Kidney disease, liver disease, or dehydration requiring medical care?	
☐	☐	**10.** Breast/uterine/ovarian/estrogen-sensitive cancer, abnormal mammogram/breast symptoms, or unexplained vaginal bleeding?	
☐	☐	**11.** Blood clot/DVT/PE, stroke/TIA, heart attack, or known clotting disorder?	
☐	☐	**12.** Current cancer treatment, fever/active infection, abscess/cellulitis, or non-healing wound?	
☐	☐	**13.** Blood thinner use, bleeding disorder, or easy/severe bruising?	
☐	☐	**14.** Eating disorder history, severe food restriction, or medically concerning appetite loss?	
☐	☐	**15.** Serious allergic reaction to injection, peptide, GLP-1 medication, hormone, topical cream, or preservative/numbing ingredient?	
☐	☐	**16.** Competitive athlete, NCAA/professional athlete, military member, or subject to drug testing?	

4. PRIOR USE & PATIENT ACKNOWLEDGMENT

Prior use of any listed therapy:

☐ No ☐ Yes: _____

Side effects or reason stopped:

_____

_____

Please initial/check:

- ☐ I understand treatment requires provider review and separate consent.
- ☐ I understand some therapies may be compounded and/or prescribed off-label.
- ☐ I understand compounded medications are not FDA-approved or reviewed by FDA for safety, effectiveness, or quality before marketing.
- ☐ I will not change dose/frequency or share medication, and will report side effects, pregnancy, surgery/procedures, medication changes, or new diagnoses.

SIGNATURE: _____

For office review: any YES response should be evaluated before treatment is prescribed or administered.