



# HCG Intake Form

All information included here will be *absolutely confidential*. If you have any questions please ask.  
Thank you.

Name \_\_\_\_\_ Age \_\_\_\_\_ M  F  Today's Date \_\_\_\_\_  
 Your Care Card Number \_\_\_\_\_ Birthdate (D/M/Y) \_\_\_\_\_  
 Home Address \_\_\_\_\_  
 City \_\_\_\_\_ Postal Code \_\_\_\_\_ Occupation \_\_\_\_\_  
 Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ E-mail Address \_\_\_\_\_  
 I give permission to be emailed occasionally about specials or new treatments: Yes  No   
 Spouse's Name \_\_\_\_\_ Children Name/Age) \_\_\_\_\_  
 Names of Other Healthcare Providers:  
 Medical Doctors \_\_\_\_\_ Naturopathic Physician \_\_\_\_\_  
 Chiropractor \_\_\_\_\_ Others \_\_\_\_\_  
 Do you have Extended Coverage? Yes  No  Do you receive MSP Premium Assistance? Yes  No

How did you hear about Dr. Polo? \_\_\_\_\_

### **HCG Weight Loss Program:**

When did you first become overweight? (your age then): \_\_\_\_\_ (year): \_\_\_\_\_  
 Your present weight: \_\_\_\_\_ Height: \_\_\_\_\_ Your goal weight: \_\_\_\_\_  
 How did your weight gain start? Describe any circumstances: \_\_\_\_\_

What do you think is the cause of your weight problem? \_\_\_\_\_  
 Your highest weight? (excl. pregnancy)? \_\_\_\_\_ Your age then? \_\_\_\_\_ # of years ago \_\_\_\_\_  
 Your lowest weight? \_\_\_\_\_ Your age then? \_\_\_\_\_ # of years ago \_\_\_\_\_  
 Have you ever stayed the same weight for 10 years or more? Yes  No   
 Have you attempted to lose weight before? Yes  No   
 Most lbs. lost? \_\_\_\_\_ How long it took? \_\_\_\_\_ Previous method(s): \_\_\_\_\_  
 Describe your experience and results: \_\_\_\_\_

Where and when do you do most of your overeating? \_\_\_\_\_  
 Please make any comments that you think might be helpful: \_\_\_\_\_

Do you currently have any medical conditions or concerns? Please List: \_\_\_\_\_

### **Past History:** Please check if you have had any of the following:

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Birth defects or abnormalities | <input type="checkbox"/> Fever German Measles (3 day) | <input type="checkbox"/> Diabetes: Type _____ | <input type="checkbox"/> Exposed to tuberculosis |
| <input type="checkbox"/> Influenza                      | <input type="checkbox"/> Chickenpox                   |   | <input type="checkbox"/> Mumps                   |

- |                                      |   |   |  |
|--------------------------------------|---|---|--|
| <input type="checkbox"/> Polio       | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Rheumatic      | <input type="checkbox"/> Cancer: Type _____    |
| <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Scarlet Fever  | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Other Diseases: _____ |
| <input type="checkbox"/> Diphtheria  | <input type="checkbox"/> Scarletina     | <input type="checkbox"/> Pneumonia      | _____  |

Current Medications (including vitamins, birth control) : \_\_\_\_\_

Allergies to medicines, foods, etc: \_\_\_\_\_

**Family History:**

Father: Health \_\_\_\_\_ Age \_\_\_\_\_ Deceased \_\_\_\_\_ At age \_\_\_\_\_ Cause \_\_\_\_\_

Mother: Health \_\_\_\_\_ Age \_\_\_\_\_ Deceased \_\_\_\_\_ At age \_\_\_\_\_ Cause \_\_\_\_\_

# of Siblings: \_\_\_\_\_ # living \_\_\_\_\_ # Deceased \_\_\_\_\_ Cause \_\_\_\_\_

Family Diseases: *Please check diseases know in your blood relatives (not yourself):*

- |  |  |  |                                      |
|--|--|--|--------------------------------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Allergy                 | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Obesity     |
| <input type="checkbox"/> Migraine            | <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Fever             | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Strokes             | <input type="checkbox"/> Syphilis or (bad blood) | <input type="checkbox"/> Anemia            |                                      |
| <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Rheumatic               | <input type="checkbox"/> Epilepsy          |                                      |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Heart trouble           | <input type="checkbox"/> Nervous breakdown |                                      |

**Examinations:**

Date of last physical examination: \_\_\_\_\_ Reason: \_\_\_\_\_ Hospitalization: \_\_\_\_\_

Dates: \_\_\_\_\_ Reason: \_\_\_\_\_ X-rays: Chest: \_\_\_\_\_ Stomach: \_\_\_\_\_

Gallbladder: \_\_\_\_\_ Kidney: \_\_\_\_\_ Colon: \_\_\_\_\_ Others: \_\_\_\_\_ Laboratory Tests: \_\_\_\_\_

Electrocardiogram (heart tracing): \_\_\_\_\_ Laboratory Tests: \_\_\_\_\_ Date of last pap test: \_\_\_\_\_

**Do you have or have had any of the following? Please check if you have had any of the following:**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Itching                  | <input type="checkbox"/> Painful urination      | <input type="checkbox"/> Nervous breakdown         | <input type="checkbox"/> Fainting              |
| <input type="checkbox"/> Eczema                   | <input type="checkbox"/> Varicose veins         | <input type="checkbox"/> Loss of consciousness     | <input type="checkbox"/> Neuritis or Neuralgia |
| <input type="checkbox"/> Hives                    | <input type="checkbox"/> Depression             | <input type="checkbox"/> Swelling glands           | <input type="checkbox"/> Asthma                |
| <input type="checkbox"/> Joint pains              | <input type="checkbox"/> Numbness               | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Heart Trouble         |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Goiter                 | <input type="checkbox"/> Bronchitis                | <input type="checkbox"/> Chest Pains           |
| <input type="checkbox"/> Leg pains                | <input type="checkbox"/> Raise sputum           | <input type="checkbox"/> Palpitation or Fluttering | <input type="checkbox"/> Indigestion           |
| <input type="checkbox"/> Pain or stiffness (neck) | <input type="checkbox"/> Tire easily            | <input type="checkbox"/> Swelling of ankles        | <input type="checkbox"/> Diarrhea              |
| <input type="checkbox"/> Lung disease             | <input type="checkbox"/> Abdominal pain         | <input type="checkbox"/> Gas or Bloating           | <input type="checkbox"/> Colitis               |
| <input type="checkbox"/> High blood pressure      | <input type="checkbox"/> Hemorrhoids            | <input type="checkbox"/> Bleeding or black stools  | <input type="checkbox"/> Hernia                |
| <input type="checkbox"/> Nausea or vomiting       | <input type="checkbox"/> Kidney disease         | <input type="checkbox"/> Trouble sleeping          | <input type="checkbox"/> Kidney Stones         |
| <input type="checkbox"/> Hard bowel movements     | <input type="checkbox"/> Pus or blood in Urine  |  | <input type="checkbox"/> Headaches             |
| <input type="checkbox"/> Jaundice                 | <input type="checkbox"/> Nervousness or anxiety |  | <input type="checkbox"/> Convulsions           |
|   |   |  | <input type="checkbox"/> Paralysis             |

**Menstrual History:**

Menstruation began at age: \_\_\_\_\_ 28 day Cycle: Yes  No  If no, how many days? \_\_\_\_\_  
Duration of bleeding: \_\_\_\_\_ Pain with Periods? Yes  No  Amount of flow: Light: \_\_\_ Medium: \_\_\_  
Heavy: \_\_\_ Date of 1<sup>st</sup> day of last: \_\_\_\_\_ Menstrual period: \_\_\_\_\_ Itching or burning? \_\_\_\_\_  
Bleeding after intercourse? Yes  No  Bleeding between periods? Yes  No   
Irritation or discharge? \_\_\_\_\_

**I have read and understand all of the above and have agreed to these statements.**

**HCG Weight Loss Program Informed Consent:**

I request the use of hCG along with strict dietary restrictions for the purpose of weight loss. I understand that as part of the program, I will be given a limited physical, orientation to the program with supporting materials and I will be instructed on how to administer the drops or injections myself.

I understand hCG is not Health Canada or FDA approved for weight loss as this application is considered "off-label use". I understand there is no medical evidence to support the use of hCG for this purpose. I agree that I am and will be under the care of another medical provider for all other conditions.

Prior to my treatment, I have fully disclosed any medical conditions or disease such as pregnancy, breast feeding, history of gallbladder disease, diabetes, autoimmune disease, HIV, heart disease, liver disease, kidney disease, uncontrolled high blood pressure, seizure disorders, blood disorder (anemia, thalassemia, hemophilia, etc.) emphysema or asthma, and any history of stroke or cancer. These contraindications have been fully discussed with me. If I fail to disclose any medical conditions that I have, I release the doctor and facility from any liability associated with this procedure.

While hCG is generally free of negative side effects, there is the possibility of the following:

- Acne
- Tiredness
- Changes in mood
- Risk of multiple pregnancies (ie: twins, triplets)
- Breast tenderness and/or enlargement
- Skin irritation at injection site
- Hair loss
- Prostate hypertrophy
- Ovarian hyperstimulation
- Blood clots
- Fluid retention

**I understand hCG treatments may involve these risks.**

**I have read and understand all of the above and have agreed to these statements.**

Patient Name: \_\_\_\_\_ Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_