POLO
HEALTH + LONGEVITY CENTRE

DR. ALLANA POLO'S HCG WEIGHT LOSS PROGRAM INTAKE FORM

All information included here is *confidential*. If you have any questions, please ask. Thank you.

Name_____ Age _____F □ M □ Today's Date _____

Care Card Number _____ Birthdate (D/M/Y) _____

Address _____ City _____ Postal Code _____

Work Phone _____Home Phone _____Email: _____

Occupation _____

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)*

- □ Birth defects or abnormalities
- □ Influenza
- □ Fever German Measles (3 day)
- □ Chickenpox
- □ Diabetes: Type _____
- □ Exposed to tuberculosis
- □ Mumps
- □ Polio
- □ Tonsillitis
- □ Diphtheria
- □ Whooping Cough
- □ Scarlet Fever
- □ Scarlatina
- □ Rheumatic Fever
- □ Frequent Colds
- □ Pneumonia
- □ Cancer: Type _____
- □ Other Diseases: _____

Current Medications (including vitamins, birth control) _____
_____

Allergies to medicines, foods, etc: _____

Family History

Father's Health _____ Age _____ Deceased _____ At age _____ Cause _____
Mother's Health _____ Age _____ Deceased _____ At age _____ Cause _____
# of Siblings: _____ # living _____ # Deceased _____ Cause _____

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

- □ High Blood Pressure
- □ Migraine
- □ Strokes
- □ Kidney Disease
- □ Arthritis
- □ Allergy
- □ Cancer
- □ Syphilis or (bad blood)
- □ Rheumatic Fever
- □ Heart trouble
- □ Diabetes
- □ Fever
- □ Anemia
- □ Epilepsy
- □ Nervous breakdown
- □ Obesity
- □ Other _____

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:*

- □ Itching
- □ Eczema
- □ Hives
- □ Joint pains
- □ Arthritis
- □ Leg pains
- □ Pain or stiffness (neck)
- □ Lung disease
- □ High blood pressure
- □ Nausea or vomiting
- □ Hard bowel movements
- □ Jaundice
- □ Painful urination
- □ Varicose veins
- □ Depression
- □ Numbness
- □ Goiter
- □ Sputum
- □ Tire easily
- □ Abdominal pain
- □ Hemorrhoids
- □ Kidney disease
- □ Pus or blood in Urine
- □ Nervousness or anxiety
- □ Nervous breakdown
- □ Loss of consciousness
- □ Swelling glands
- □ Emphysema/ Bronchitis
- □ Palpitation or Fluttering
- □ Swelling of ankles
- □ Gas or Bloating
- □ Bleeding or black stools
- □ Trouble sleeping
- □ Fainting
- □ Neuritis or Neuralgia
- □ Asthma
- □ Heart Trouble
- □ Chest Pains
- □ Indigestion
- □ Diarrhea
- □ Colitis
- □ Hernia
- □ Kidney Stones
- □ Headaches
- □ Convulsions
- □ 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 1st 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 agree to these statements.

INFORMED CONSENT HCG WEIGHT LOSS PROGRAM

Dr. Polo has explained the HCG program to me in full detail using her approved guidebook and I understand the program involves the daily self-administered injection of HCG or any other form of the hormone HCG (Human Chorionic Gonadotropin) with a minimum intake of 500 calories per day, modifying ifnecessary, as discussed and decided upon.

I understand that HCG has been historically used and is commonly prescribed for weight loss by physicians,but HCG used for weight loss is an "**off label**" use and is not FDA- approved nor has it been scientifically determined to reduce weight.

The rate of weight loss is 0.5 pounds per day and can be up to 1.0 pound per day. I agree to follow the outlined program discussed by Dr. Polo, and the weekly visits that are involved.

I have fully disclosed any medical conditions in my Intake Forms.
I have also fully disclosed all medication that I am currently taking.

I am aware that Dr. Polo does not use this weight loss program with people who have any of the followingconditions and **I confirm that none of these apply to me**:

- ► Uncontrolled Diabetes
- ► Uncontrolled High Blood Pressure
- ► Cancer History
- ► Stroke History
- ► Hyperthyroidism
- ► Seizure Disorders
- ► Blood Clots
- ► Pituitary or Ovarian Tumours
- ► Unstable Gout
- ► Unstable Angina

For Women

I confirm that I am not pregnant nor currently breast feeding. If I am on birth control, I understand that I need to use a secondary method while on this weight loss program.

I am aware that although the use of HCG is generally free of negative side effects, there is the possibility of the following: headache, fatigue, constipation, bruising at injection site, and temporary variation in menstrual cycle. Other possibilities include: prostate enlargement, breast tenderness and ovarian hyper stimulation syndrome.

The HCG program has been explained to me and I have been given the program booklet. As well, I have been instructed on how to self-administer the daily HCG injection and where another form of the HCG has been prescribed to me, I have been instructed on how to take this form as well.

Payment in full is required at the time of your initial intake appointment with Dr. Polo;

There are no refunds for Dr. Polo's Pound A Day Weight Loss Program and all sales are final;

Should you need to put Dr. Polo's Pound A Day Weight Loss Program on hold for medical reasons, all remaining credits will expire in 90 days from the original purchase date;

Polo Health + Longevity Centre requires a minimum of 24 hours' notice if you wish to cancel or reschedule your appointment, failing which you will be charged for the time set aside for you and that appointment. The credit for that day's appointment will be applied as a cancellation/no show fee.

Out of respect for the patients wanting to get in to see Dr. Polo and out of respect for Dr. Polo herself and her time, we ask that you adhere to the cancellation policy.

I give my informed consent for Dr. Polo's HCG Weight Loss Program.

_____ _____

Patient Signature Date

We are pleased to welcome you to Polo Health + Longevity Centre. Dr. Polo and her team welcome you and you and are looking forward to helping you as you embark on your weight loss journey.