POLO
HEALTH + LONGEVITY CENTRE

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

All information included here is *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:*

- □ 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: Health _____ Age _____ Deceased _____ At age _____ Cause _____

Mother: 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 if necessary, 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 following conditions 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 are looking forward to helping you as you embark on your weight loss journey.