MY LADY BUSINESS
Healthcare for Women of Color
Dr. Tina Marie

Asynchronous Weight Loss Appointment

Skip the office visit! Our asynchronous weight loss appointment is designed for busy women on-the-go who want powerful, evidence-based GLP-1 support without the hassle.

After **completing a secure online intake form and uploading recent labs**, our provider will review your health history and weight-loss goals to create a customized medical prescription plan featuring GLP-1 medications (like semaglutide or tirzepatide) with supportive vitamin therapy. You'll receive your personalized plan, dosing schedule, and instructions directly in your patient portal within 48-72 hours. A follow up appointment may be scheduled at your discretion. There will be a follow up questionnaire after each prescription to monitor your progress.

Perfect for women looking for convenience, privacy, and effective clinical support on their weight-loss journey without needing to book a live appointment.

My Lady Business ***reserves the right to call or text IF there are needed clarifications for your health and safety.***

My Lady Business will establish HIPPA Compliant medical record to order medications and to foster communication should you have questions

Full Name: _____

Email Address: _____ **Mobile Number:** _____

Mailing Address: _____

Billing Address: _____

☐ **Check if the same as mailing address** What is your state of residence? _____

1. Select the concerns that matter most to you, and we'll help create a personalized treatment plan to reach your wellness goals.

☐ Weight loss/management ☐ Peri/Menopause

☐ Period Irregularities ☐ Thyroid Management

☐ Cortisol Management

☐ Metabolic Health (Cholesterol, Blood Pressure, Insulin Resistance, Deficiencies)

☐ Other (please describe) _____

2. What is your current height and weight? Ht_____ Weight_____
3. What is your goal weight: _____lbs
4. When was the last time you were at this weight?

   ☐ 1-3yrs ☐ >5yrs ☐ >10yrs
5. Are you currently pregnant, breastfeeding or planning to become pregnant?

   ☐ Yes ☐ No

6. Do you have any known allergies to foods or medications? Please specify

   _____

   _____

   _____
7. Please list any current PRESCRIPTION medications:

   _____

   _____

   _____

   _____

   _____
8. Please list any current SUPPLEMENTS and Over the Counter Medications:

   _____

   _____

   _____

   _____

   _____
9. Please List any SURGERIES you have had

   _____

   _____

   _____

10. Do you have any diagnosed medical conditions?

- ☐ Cardiovascular/heart disease
- ☐ Irregular heartbeat
- ☐ High Blood Pressure
- ☐ High cholesterol
- ☐ Anemia/ iron deficiency
- ☐ Pancreatitis
- ☐ Blood clotting disorders (e.g., DVT, pulmonary embolism)
- ☐ Type 2 diabetes or insulin resistance
- ☐ Sleep apnea
- ☐ Depression or anxiety
- ☐ Thyroid disorders
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Autoimmune disorders: (Please specify):_____
- ☐ Osteoporosis or bone density issues
- ☐ Cancer (current or past): Please specify the TYPE of cancer: _____
- ☐ Neurodegenerative conditions (e.g., Alzheimer's, Parkinson's)
- ☐ Hormonal imbalances (e.g., PCOS, PMDD, endometriosis etc)
- ☐ Skin conditions (e.g., eczema, psoriasis, seborrheic dermatitis)
- ☐ Gastrointestinal disorders (e.g., GERD, Irritable Bowl, Chronic Constipation)
- ☐ Menopause (natural or surgical)
- ☐ Hair loss
- ☐ Eating disorder (e.g., anorexia, bulimia, binge eating disorder)
- ☐ Other: (please list any other diagnosis not listed above)

_____

_____

_____

_____

_____

11. How would you rate your diet?

- ☐ Healthy and Balanced
- ☐ Moderately Healthy
- ☐ Poor

12. Do you follow any dietary restrictions? (Keto, vegetarian, intermittent fasting etc)

_____

13. Do you sleep 6-8 hours per night? ☐ Yes ☐ No
14. Do you engage in regular physical activity ☐ Yes ☐ No
15. How would you rate your stress levels

- ☐ Low
- ☐ Moderate
- ☐ High

16. Do you smoke or vape? ☐ Yes ☐ No
17. Do you consume alcohol? ☐ Yes ☐ No
18. Do you use recreational drugs? ☐ Yes ☐ No (specify): _____
19. Have you previously used GLP1? ☐ Yes ☐ No

(Specify Brand, when it was used, length of time used, last used, weight lost) :

_____

20. Is there anything else you would like your provider to know about your health or goals? (optional)

_____

_____

_____

_____

_____

Disclaimer & Consent: Review and accept the terms so we can safely proceed with your care

☐ By submitting this questionnaire, you confirm that the information provided is accurate to the best of your knowledge

☐ I consent to this information being reviewed by a licensed medical professional to determine your eligibility for care.

☐ I authorize My Lady Business providers to support my wellness plan, which may include compounded medications from licensed pharmacies, supplements, lifestyle and behavioral modifications.

☐ I understand that medical treatments carry risks, and that an unhealthy lifestyle or altering the medication regimen without my providers advice can lead to serious health conditions.

☐ I understand that my effort is key to the program's success and that results are not guaranteed.

Signature: _____ **Date:** _____