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

MY LADY BUSINESS — ASYNCHRONOUS GLP-1 MONTHLY FOLLOW-UP QUESTIONNAIRE

To be completed every 30 days while enrolled in our GLP-1 medical weight loss program.

PATIENT INFORMATION

Full Name: _____

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

Billing Address: _____

☐ **Check if the same as mailing address** **State of Residence:** _____

Date of Birth: _____ **Today's Date:** _____

Current Medication: ☐ Semaglutide ☐ Tirzepatide ☐ Other: _____

Current Dose: _____

SECTION 1 — WEIGHT LOSS PROGRESS

Current Weight: _____ lbs **Weight at start of program:** _____ lbs

Overall progress so far:

☐ Significant progress ☐ Moderate progress ☐ Minimal progress ☐ No progress

How satisfied are you with your weight loss this month?

☐ Very satisfied ☐ Satisfied ☐ Neutral ☐ Unsatisfied ☐ Very unsatisfied

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SECTION 2 — APPETITE & HABITS

How would you rate your **appetite** compared to last month?

☐ Much less ☐ Slightly less ☐ About the same ☐ Slightly more ☐ Much more

Are you experiencing **cravings**?

☐ No ☐ Occasionally ☐ Frequently ☐ Constantly

On average, how many **days per week** do you engage in *intentional physical activity (exercise/walking)*?

☐ 0 ☐ 1–2 ☐ 3–4 ☐ 5+

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SECTION 3 — GASTROINTESTINAL SIDE EFFECTS

In the **past 4 weeks**, how often have you experienced the following:

Symptom	None	Mild	Moderate	Severe	Notes
Nausea	☐	☐	☐	☐	_____
Vomiting	☐	☐	☐	☐	_____
Constipation	☐	☐	☐	☐	_____
Diarrhea	☐	☐	☐	☐	_____
Heartburn/Reflux	☐	☐	☐	☐	_____
Bloating/Fullness	☐	☐	☐	☐	_____

SECTION 4 — OTHER SYMPTOMS

Symptom	Yes	No	If yes, describe
Fatigue / low energy	☐	☐	_____
Dizziness or lightheadedness	☐	☐	_____
Injection site irritation	☐	☐	_____
Hair thinning or shedding	☐	☐	_____
Mood changes	☐	☐	_____
Anything else new or concerning?	☐	☐	_____

SECTION 5 — MEDICATION USE & DOSE TOLERANCE

Are you taking your medication consistently as prescribed?

☐ Yes ☐ No (explain): _____

Have you missed any doses this month?

☐ No ☐ Yes — how many? _____

How well are you tolerating your current dose?

☐ Very well ☐ Fair ☐ Poor (would like adjustment)

Are you ready to **stay at same dose**, **increase dose**, or **decrease dose**?

☐ Stay the same ☐ Increase ☐ Decrease

SECTION 6 — ADDITIONAL SUPPORT

Do you feel you need additional support with:

Nutrition ☐ | Exercise ☐ | Motivation ☐ | Lab testing ☐

Any specific **questions or requests for your provider** this month?

Signature

☐ I attest that the information provided above is true and accurate to the best of my knowledge.

☐ I have received information regarding the purpose, potential benefits, and risks associated with GLP-1 medications.

☐ This program is **not a substitute** for regular medical care. I should continue routine medical care with my primary healthcare provider.

☐ I understand that results may vary and are dependent on adherence to the prescribed program, including diet, exercise, and lifestyle recommendations.

☐ I am responsible for reporting any side effects or adverse reactions promptly to My Lady Business.

☐ My Lady Business is not responsible for medical complications arising from undisclosed health conditions, failure to follow instructions, or outside medical advice that conflicts with program guidelines.

☐ I understand that My Lady Business providers may adjust doses or recommend alternative therapies based on my health status and progress.

☐ Participation in the program is voluntary, and I may withdraw with notification to My Lady Business. Medications cannot be refunded once ordered. Medications are dispensed within 1 day of payment.

Signature: _____ **Date:** _____