WEST TENNESSEE EYE CARE, P.C. dba TOYOS CLINIC

Please complete all blanks

Name: First: _____ MI:_____ Last: _____

DOB: _____ Social Security #:_____-_____-_____

Mailing Address:

Street Address: _____

City: _____ State: _____ Zip: _____

Contact Information:

Home Phone: (_____)_____-_____ Cell: (_____)_____-_____

*Can we leave a detailed message on these numbers? Y or N (Please circle one)

Email Address:_____ Occupation: _____

*Preferred Method of contact? **(**Please Circle**)** Phone Text Email

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Please Circle or Complete:

Sex: M / F ***Gender Identity*: _____** ***Marital Status***: Single / Married / Divorced / Widowed

Race: American Indian or Alaska Native / Asian / Black or African American
Native Hawaiian / Other Pacific Islander / White / Other: _____ (Please Specify)

***Ethnicity*:** Hispanic or Latino / Non-Hispanic or Latino

Emergency Contact Information: Name**:** _____ Phone #: _____
Relationship to Patient: _____

Insurance Information: (Please provide insurance cards to front desk)

Insurance Policy Holder Information (if other than patient):

Name: _____ Date of Birth: _____ Phone #: _____
Social Security #: _____ Relationship to Patient: _____
Address: _____ City: _____ State: ____ Zip: _____

Parent or Guardian Information (if patient is younger than 18):

Name: _____ Date of Birth: _____ Phone #:_____
Address: _____ City: _____ State: ____ Zip: _____
Relationship to Patient: _____

I am interested in learning about the following services/products:

Refractive Surgery Vitamins for Eye Health Cosmetic Procedures Skin Care Dry Eye

The above information is true and correct to the best of my knowledge:

Patient/Guardian Signature: _____ Date: _____

WEST TENNESSEE EYE CARE, P.C. dba TOYOS CLINIC

CONSENT FOR TREATMENT AND CARE

I, the undersigned, do hereby agree and give my consent for West Tennessee Eye Care, P.C. to furnish medical care and treatment to myself or _____which is considered necessary and appropriate in diagnosing or treating my/their physical condition.

STATEMENT OF FINANCIAL RESPONSIBILTY

All services rendered are the responsibility of the patient. As a courtesy to our patients, we will file with your insurance carrier. The patient is responsible for all fees, regardless of insurance coverage or the usual and customary fees provided by your insurance company. Payment is expected at the time of treatment unless prior arrangements have been made with our office. I understand that in the event that my account is placed with a collection agency, a collection fee of up to 33.3% may be added to my account and shall become a part of the total amount due. In the event my account is placed with an attorney, I will be responsible for reasonable attorney fees and court costs. I agree, that in order for you to service my account or to collect any amounts I may owe, WTEC and your collection agencies may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. WTEC and your collection agencies may also contact me by sending text messages and/or emails, using any email address I provide to use. Methods of contact may include pre-recorded/artificial voice messages and/or use of an automatic dialing device, if applicable.

INSURANCE AUTHORIZATION AND BENEFITS ASSIGNMENT

I hereby authorize West Tennessee Eye Care, P.C. to release all information necessary, including medical records, requested by insurance companies with whom I have coverage and any public agency or its agents to secure payment for myself or my dependents. I hereby authorize payment or benefits to be made directly to West Tennessee Eye Care, P.C. for services provided to me or my dependents.

MEDICARE and/or MEDIGAP ONE-TIME AUTHORIZATION

I request that payment for authorized Medicare and/or Medigap benefits be made on my behalf to West Tennessee Eye Care, P.C. for any services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits or the benefits payable for related services.

CLAIM FILING CONSENT

I agree to give Greenway Revenue Services authorization to file insurance for medical claims on behalf of West Tennessee Eye Care, PC.

ADVANCED DIRECTIVES

I have a living will or durable power of attorney. ___Yes ___No
If you do have a durable power of attorney, please identify: _____

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have received West Tennessee Eye Care's Notice of Privacy Practices.

_____ _____
Name of Patient Patient's Date of Birth

_____ _____
Signature of Patient/Guardian/Parent Date

This acknowledgement page should be retained in patient's record. If acknowledgement could not be obtained for patient, the reasons must be documented.

Toyos Clinic - Medical History Questionnaire

Name: _____ Age/Race/Gender: _____ Date: _____

Other Doctors participating in your care (Name/Specialty/Location): _____

_____

Reason for today's exam: _____

Family History: Do your parents, siblings, or children have any of the following? **Please circle** and indicate the relationship.

Diabetes High Blood Pressure Cancer Retinal Detachment Glaucoma Blindness

Other Details: _____

Personal History: Are you currently taking medication for or have you ever been diagnosed or treated for the following conditions?

AUTOIMMUNE

- ☐ Lupus
- ☐ Psoriasis
- ☐ Rheumatoid Arthritis
- ☐ Sjögren's Syndrome
- ☐ Other: _____

CARDIOVASCULAR

- ☐ Angina
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irregular Heart Beat
- ☐ Murmur
- ☐ Pacemaker or Bypass
- ☐ Stroke
- ☐ Valve Replacement
- ☐ Vascular Disease

CONSTITUTIONAL

- ☐ Cancer, Type: _____
- ☐ Fever
- ☐ Sleep Disorder, Type: _____
- ☐ Weight Loss/Gain

ENDOCRINE

- ☐ Diabetes: Insulin Dependent (Circle) Type 1 / Type 2
- ☐ Diabetes: Non-Insulin Dependent
- ☐ Pre-Diabetic
- ☐ Thyroid Abnormality
- ☐ Thyroid Disease

EARS, NOSE, MOUTH, THROAT

- ☐ Chronic Cough
- ☐ Dry Throat/Mouth
- ☐ Seasonal Allergies
- ☐ Sinus Congestion

GENITOURINARY

- ☐ Kidney Stones
- ☐ Polycystic Ovary Syndrome (PCOS)
- ☐ Prostate Disorder
- ☐ STD, Type: _____

GASTROINTESTINAL

- ☐ Constipation
- ☐ Diarrhea
- ☐ Gerd
- ☐ Reflux

HEMATOLOGICAL/LYMPHATIC

- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Hepatitis B/C
- ☐ HIV/AIDS
- ☐ Tuberculosis

INTEGUMENTARY

- ☐ Eczema
- ☐ Rosacea

MUSCULOSKELETAL

- ☐ Gout
- ☐ Osteoarthritis
- ☐ Paralysis, Type: _____
- ☐ Other: _____

NEUROLOGICAL

- ☐ Headaches
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Seizures

OCULAR

- ☐ Blindness
- ☐ Cataracts
- ☐ Cataract Surgery
- ☐ Contact Lenses
- ☐ Crossed Eyes
- ☐ Glasses
- ☐ Glaucoma
- ☐ Keratoconus
- ☐ Laser Eye Surgery
- ☐ Lazy Eye
- ☐ Macular Degeneration
- ☐ Ocular Injury/Trauma
- ☐ Other Eye Surgery
- ☐ Retinal Detachment

PSYCHIATRIC

- ☐ Anxiety
- ☐ Bipolar
- ☐ Depression
- ☐ Schizophrenia
- ☐ Other: _____

RESPIRATORY

- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Emphysema
- ☐ Pneumonia

Other/Details: _____

General Surgeries: _____

Allergies to Medications: _____

Toyos Clinic - Medical History Questionnaire

Ocular History:

Date of your last eye exam: _____

Do you have glasses? (Please circle one) Yes / No

If yes, how old are your glasses? _____

Do your glasses have prism? (Please circle one) Yes / No / Unsure

Do you have contacts? (Please circle one) Yes / No

If yes, are you currently wearing your contacts? (Please circle one) Yes / No

How many years have you worn contacts? _____

What type of contacts do you wear? (Please circle one) Soft / Toric / RGP / Scleral

What brand of contacts do you wear? _____

Social History: (Please circle and indicate as necessary)

Smoking Status: Never Smoker / Former Smoker / Current Smoker -- Amount: _____

Alcohol Consumption: Heavy / Moderate / Occasional / Never

Recreational Drug Use: Yes / No

Medications: Please list all medications you are currently taking. Include eye drops, vitamins, and homeopathies. If you have a pre-printed list, please allow the front desk to make a copy.

Name of Drug	Dosage	What is the medication for?

Preferred Pharmacy:_____ **Pharmacy Phone Number:**_____

Patient's Signature:_____ **Date**: _____

ToyosClinic

MELISSA TOYOS, M.D.
Ophthalmology and Facial Plastic Surgery
Hair Restoration Surgery

Weight Loss Consultation Form

General Information

Patient Name	Date of Birth
Current Weight (lbs)	Height

Please answer the following questionnaire as completely as possible.

Who is your primary care physician/family doctor? _____

What is the most you have weighed as an adult? _____ **lbs. Age at this weight?** _____

What is the least you have weighed as an adult? _____ **lbs. Age at this weight?** _____

What would you like to weigh? _____ **lbs.**

How has your weight changed during your life? (Check all that apply)

- ☐ Gradual increase with a small amount each year
- ☐ One or more rapid increase(s) in weight
- ☐ Up and down

What has caused you to gain weight in the past? (Check all that apply)

- ☐ Illness/Injury, describe: _____
- ☐ Quitting Smoking, describe: _____
- ☐ Menopause, describe: _____
- ☐ Medications, describe: _____
- ☐ Stress, describe: _____
- ☐ Other, describe: _____

What are you hoping the Weight Loss Medicine can do for you? (Check all that apply)

- ☐ Improve health/Feel better
- ☐ Increase energy/Allow me to do more daily activities
- ☐ Lose Weight
- ☐ Prevent medical problems
- ☐ Reverse medical problems/Allow me to stop medications
- ☐ Other, describe: _____

Have you ever had weight loss surgery?

- ☐ Yes
- ☐ No

If yes, what type of surgery?_____ **Date:**_____ **Weight lost:** _____

Are you interested in weight loss surgery?

- ☐ Yes
- ☐ No

Are you taking any type of birth control?

- ☐ Yes
- ☐ No

If yes, what type of birth control?_____

How many children under the age of 18 live with you?

_____ Child(ren) _____ Grandchild(ren) _____ Other

Please check if any family members are (or were) overweight or obese:

- ☐ Spouse
- ☐ Father
- ☐ Mother
- ☐ Brother
- ☐ Sister
- ☐ Daughter
- ☐ Son
- ☐ Grandparent
- ☐ Other

Will your family support you in your weight loss?

- ☐ Yes
- ☐ No
- ☐ Maybe

ToyosClinic

MELISSA TOYOS, M.D.
Ophthalmology and Facial Plastic Surgery
Hair Restoration Surgery

Prior Medical History

Are you currently taking medication for or have you ever been diagnosed or treated for any of the following conditions?

Autoimmune Disorders
- ☐ Lupus
- ☐ Rheumatoid arthritis

Cardiovascular
- ☐ Clotting disorder
- ☐ Heart attack
- ☐ Heart murmur/valve problems
- ☐ Heart failure
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Peripheral artery disease

Endocrine
- ☐ Diabetes, age at diagnosis: _____
  - ☐ Damage to kidneys from diabetes
  - ☐ Damage to eyes from diabetes
  - ☐ Damage to nerves from diabetes
- ☐ Liver disease
- ☐ Thyroid disease
- ☐ Pancreatitis

Gastrointestinal
- ☐ Crohn's disease
- ☐ Colitis
- ☐ Reflux/Heartburn
- ☐ Gallstones

Genitourinary
- ☐ Dialysis
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Polycystic Ovarian Disease (PCOS)

Hematological/Lymphatic
- ☐ Hepatitis
- ☐ HIV/AIDS

Immunologic
- ☐ Cancer, type: _____
- ☐ Organ transplant, type: _____

Musculoskeletal
- ☐ Gout
- ☐ Other rheumatologic disease

Neurological
- ☐ Epilepsy (seizures)
- ☐ Stroke

Psychiatric
- ☐ Anxiety
- ☐ Depression

Respiratory
- ☐ Asthma
- ☐ Emphysema, COPD
- ☐ Obstructive sleep apnea
- ☐ Pulmonary embolism

Ocular
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Other, describe: _____

Other medical conditions, please list:

_____
_____
_____

ToyosClinic

Melissa Toyos, M.D.
Ophthalmology and Facial Plastic Surgery
Hair Restoration Surgery

Indicate which of the following diets, diet aids, or programs you have tried and please list the start and stop dates, amount of weight lost, reason for stopping, and amount of weight regained after stopping.

Diet or program	Tried?	Start Date	Stop Date	Amt of weight lost	Reason for stopping	Amt weight regained after stopping
On your own	Y / N					
Atkins/Low Carb	Y / N					
UAB EatRight	Y / N					
Jenny Craig	Y / N					
Nutrisystem	Y / N					
Weight Watchers	Y / N					
Slimfast	Y / N					
Optifast	Y / N					
Ozempic	Y / N					
Other Semaglutide	Y / N					
Other Liquid Diet	Y / N					
Herbal Products	Y / N					
Phentermine	Y / N					
Orlistat	Y / N					
Lorcaserin	Y / N					
Sibutramine	Y / N					
Qsymia	Y / N					
Redux	Y / N					
Other (specify)						

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MELISSA TOYOS, M.D.
Ophthalmology and Facial Plastic Surgery
Hair Restoration Surgery

Please indicate if you have a history of any of the following:

- ☐ **Eating Disorder:** Yes / No / Not Sure
- ☐ **Anorexia Nervosa:** Yes / No / Not Sure
- ☐ **Binge Eating:** Yes / No / Not Sure
- ☐ **Bulimia/Intentional Vomiting:** Yes / No / Not Sure
- ☐ **Eating so much at once that you have to vomit:** Yes / No / Not Sure

---

Please answer the following sleep/restfulness questions:

On average over the past month, how many hours of sleep did you get per night? _____

Do you feel rested when you wake up?

- ☐ Yes
- ☐ No
- ☐ Not Sure

Do you snore?

- ☐ Yes
- ☐ No
- ☐ Not Sure

Have you ever been told to wear a CPAP or BiPAP for sleep apnea?

- ☐ Yes
- ☐ No

If yes, how many nights per week? _____

How well have you slept over the past month? Very good / Fairly good / Fairly bad / Very bad

In the last two weeks, how likely were you to doze off or fall asleep in the following situations? Please check the best option for each situation.

Situation	Never (0)	Slight Chance (1)	Moderate Chance (2)	High Chance (3)
Watching TV				
Sitting and reading				
Sitting in a public place				
Passenger in a car for 1+ hour				
Lying down to rest in the afternoon				
Sitting down and talking to someone				
After eating a meal (without alcohol)				
In a car, while stopped for a few minutes in traffic				

Total Score: _____

Additional information related to exercise:

On a typical day, which best describes your movement level?

- ☐ Mostly sedentary
- ☐ Light exercise/walking
- ☐ Moderate exercise/walking
- ☐ Heavy physical labor
- ☐ Unsure
- ☐ Other, describe: _____

Do you enjoy exercise?

- ☐ Yes
- ☐ No

Do you have a gym membership?

- ☐ Yes
- ☐ No

Do you have exercise equipment at home?

- ☐ Yes
- ☐ No

Do you exercise regularly?

- ☐ Yes
- ☐ No

Do you have any negative feelings about exercise or had any bad experiences with exercise?

- ☐ Yes
- ☐ No

Do you have any family or friends who are willing to encourage you to exercise regularly or exercise with you?

- ☐ Yes
- ☐ No

How much have you exercised in the past WEEK?

Type of exercise: _____

Length of exercise: _____ **Hours/Minutes**

How long have you been exercising regularly? (At least 150 minutes per week - Ex. 30-minute sessions, 5 days/week) _____ **months**

Were you an athlete in school? (Check all that apply)

- ☐ Yes, High School
- ☐ Yes, College
- ☐ No
- ☐ Other, describe: _____

What types of exercise are you currently involved in? (Check all that apply)

- ☐ Aerobics classes
- ☐ Biking, outdoor
- ☐ Biking, stationary
- ☐ CrossFit/Boot Camp
- ☐ Elliptical machine
- ☐ Exercise videos
- ☐ Hiking
- ☐ Pilates
- ☐ Running
- ☐ Stretching
- ☐ Swimming
- ☐ Walking
- ☐ Water/Pool exercise
- ☐ Weight training
- ☐ Yoga
- ☐ Zumba
- ☐ None
- ☐ Other, describe: _____

How confident are you that you could increase the amount of exercise that you do?

- ☐ Very confident
- ☐ Moderately confident
- ☐ Not very confident
- ☐ Not confident

What are the major benefits of exercise for you? (Check all that apply)

- ☐ Increased energy
- ☐ Improved health
- ☐ Improved arthritis
- ☐ Improved mobility
- ☐ Other, describe: _____

What barriers prevent you from exercising more? (Check all that apply)

- ☐ Lack of motivation
- ☐ Lack of time
- ☐ Lack of equipment
- ☐ Lack of access to exercise facilities
- ☐ Injuries
- ☐ Health problems
- ☐ Not applicable
- ☐ Other, describe: _____

How much time are you able to commit to exercise? _____ min/day _____ days/week

Additional information related to diet:

How confident are you that you can follow a weight loss diet?

- ☐ Very confident
- ☐ Moderately confident
- ☐ Not very confident
- ☐ Not confident

What barriers prevent you from following a weight loss diet? (Check all that apply)

- ☐ Access to healthy foods
- ☐ Access to cooking appliances
- ☐ Access to refrigerator and/or freezer
- ☐ Cost
- ☐ Family/household diet
- ☐ Food intolerances/allergies
- ☐ Healthy food doesn't taste good
- ☐ Hunger level
- ☐ Lack of family/peer support
- ☐ Lack of knowledge of food to eat/buy
- ☐ Religion
- ☐ Time to plan/prepare healthy meals
- ☐ Work atmosphere
- ☐ Other, describe: _____

How many times a day do you eat? _____

At what times of day do you eat?

- ☐ Morning
- ☐ Mid-morning
- ☐ Noon
- ☐ Afternoon
- ☐ Evening
- ☐ Late night/bedtime
- ☐ Middle of the night

How many people live in your home? _____ **Are meals eaten together?** Yes / No

Who does the grocery shopping for your household?

- ☐ Yourself
- ☐ Spouse
- ☐ Parent
- ☐ Other, describe: _____

Who cooks/prepares meals in your household?

- ☐ Yourself
- ☐ Spouse
- ☐ Parent
- ☐ Other, describe: _____

Have you done or experienced any of the following in the past 6 months? (Circle one)

Situation	Y/N	Details/Comments
Eating when stressed, emotional, or bored	Y / N	
Binge eating	Y / N	
Grazing or frequent snacking	Y / N	
Eating in the middle of the night	Y / N	
Skipping meals	Y / N	
Eating out or ordering takeout	Y / N	
Eating in front of the TV	Y / N	
Eating at a desk/computer/while working	Y / N	
Eating more than one helping/large portions	Y / N	
Do NOT feel satisfied or full after a meal	Y / N	

Which of the following do you consume more than once per week? If so, how many times per day on average?

- ☐ Regular soda, ____ per day
- ☐ Juice, ____ per day
- ☐ Sweet tea, ____ per day
- ☐ Alcoholic drinks, ____ per day
- ☐ Fried foods, ____ per day

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Ophthalmology and Facial Plastic Surgery
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Indicate the number of servings you typically consume per day for each of the following:

____ Fruit ____ Vegetables ____ Whole Grains ____Low-Fat Dairy ____ Lean Protein

Do you have any food intolerances or food allergies, or are there particular foods that you dislike?

- ☐ Yes
- ☐ No

If yes, please describe: _____

Do you have any food cravings?

- ☐ Yes
- ☐ No

If yes, please describe: _____

How did you hear about our office?

- ☐ Family/Friend/Coworker
- ☐ Internet
- ☐ Physician
- ☐ Advertisement
- ☐ Other:_____

The above information is true and correct to the best of my knowledge.

Patient Signature Date

ToyosClinic

See Better, Look Better

Informed Consent for Injectable Compounded Liraglutide for Weight Loss. I, _____
I understand that I am being prescribed compounded liraglutide, a GLP-1 receptor agonist, for weight loss and weight management. This medication is administered by subcutaneous injection and is not FDA-approved for weight loss in its compounded form, although Liraglutide (brand name Saxenda®) is FDA-approved for obesity.

By signing here, you acknowledge that this disclosure has been made and that have read and understand this disclosure.

Patient Signature: _____ Date: _____

_____ **(initial here)** I understand that **Liraglutide** is a medication that works by reducing appetite and food intake, slowing gastric emptying, increasing satiety, and improving blood sugar control.

_____ **(initial here)** I acknowledge that the Liraglutide I am receiving is a **compounded medication** prepared by a licensed pharmacy. I understand that this formulation is not manufactured by the original drug company, Novo Nordisk, and that it is **not approved by the FDA** in its compounded form. This compounded version may differ slightly in its formulation or delivery system from the branded product and is being prescribed **off-label**.

_____ **(initial here)** I have been informed that **possible benefits** of taking compounded Liraglutide may include weight loss, improved blood sugar control, decreased appetite, and improved metabolic parameters.

_____ **(initial here)** I understand that there are **potential risks and side effects**, which may include nausea, vomiting, diarrhea, constipation, headache, fatigue, injection site reactions, pancreatitis (which is rare but serious), gallbladder disease, increased heart rate, and hypoglycemia, particularly if combined with other glucose-lowering medications. I have been informed that Liraglutide carries a **Black Box Warning** due to an association with thyroid C-cell tumors in rodents, although it is not known if this risk applies to humans.

_____ **(initial here)** I understand that this medication is **not appropriate** for individuals with a personal or family history of medullary thyroid carcinoma (MTC), multiple endocrine neoplasia syndrome type 2 (MEN 2), a history of pancreatitis, or known hypersensitivity to Liraglutide or any components of the formulation.

_____ **(initial here)** I acknowledge that **Liraglutide is not recommended during pregnancy or while breastfeeding**, and I agree to notify my healthcare provider immediately if I become pregnant or plan to conceive.

_____ **(initial here)** I understand the importance of **regular follow-up and monitoring**, including tracking weight, conducting laboratory tests, and reporting any symptoms while on this medication. I agree to comply with all recommended follow-up visits and testing.

_____ **(initial here)** I have been informed of **alternative treatment options**, including lifestyle modifications (such as diet and exercise), other FDA-approved weight loss medications, and bariatric surgery.

_____ **(initial here)** I acknowledge that my **participation in this treatment is voluntary**, and I may discontinue it at any time. I understand that no guarantees have been made regarding the outcomes of this treatment.

I confirm that I have had the opportunity to ask any questions regarding this treatment. I fully understand the potential risks, benefits, and alternatives associated with compounded Liraglutide.

_____	_____	_____
Patient Name (print)	Patient Signature	Date

_____	
Doctor Signature	Date

ToyosClinic

HOW TO INJECT COMPOUNDED LIRAGLUTIDE

(For Subcutaneous Use Only – Follow Your Provider's Instructions)

WEEKLY DOSING SCHEDULE

- **Week 1**

Inject 5 units SQ

- **Week 2**

Inject 10 units SQ

- **Week 3**

Inject 15 units SQ

- **Week 4**

Inject 20 units SQ

- **Week 4**

Inject 25 units SQ

- "SQ" = Subcutaneous injection (under the skin)
- Inject once daily, at the same time each day

STEP-BY-STEP INSTRUCTIONS

- Wash Your Hands.
- Prepare the medication, draw correct dose into insulin syringe.
- Choose injection site; Preferred sites: abdomen, thigh, or upper arm. *Rotate injection sites daily.*
- Use an alcohol swab to wipe the site.
- Inject the Medication.
- Pinch the skin *(optional)*
- Insert needle at a 45°–90° angle.
- Slowly push plunger to inject the full dose.
- *Wait a few seconds before withdrawing.*
- Dispose of Needle Safely.
- Keep refrigerated (36°F to 46°F / 2°C to 8°C). *Do not freeze.*