FN SOLUTIONS

Client Medical History & Peptide Intake Form

Please complete all fields accurately and honestly. This information is used to ensure your safety and determine the most appropriate peptide protocol for you.

1. Client Information

Full Legal Name: _____

Date of Birth: _____

Phone Number: _____

Email Address: _____

Mailing Address: _____

City: _____ **State:** _____ **ZIP Code:** _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Date of Form Completion: _____

Referred By: _____

2. Primary Wellness Goals

Check all that apply:

- ☐ Weight / Fat Loss
- ☐ Energy & Stamina
- ☐ Hormonal Balance
- ☐ Cognitive Enhancement
- ☐ Immune Support
- ☐ Gut Health
- ☐ Muscle Building & Recovery
- ☐ Anti-Aging & Longevity
- ☐ Sleep Improvement
- ☐ Injury Recovery
- ☐ Libido & Sexual Health
- ☐ General Wellness

Other goals not listed above: _____

_____

3. General Health

Height: _____ **Weight (lbs):** _____ **Biological Sex:** _____

Primary Care Physician Name: _____

Physician Phone: _____

Rate your current overall health:

☐ Excellent ☐ Good

☐ Fair ☐ Poor

Are you currently under the care of a physician or specialist?	☐ Yes	☐ No
If yes, please explain: _____		
Have you had any surgeries in the past 5 years?	☐ Yes	☐ No
If yes, please explain: _____		
Are you pregnant, breastfeeding, or planning to become pregnant?	☐ Yes	☐ No
If yes, please explain: _____		
Have you ever been diagnosed with cancer or are currently in treatment?	☐ Yes	☐ No
If yes, please explain: _____		

4. Current & Past Medical Conditions

Check all that apply — past or present:

☐ Diabetes (Type 1 or 2) ☐ Thyroid Disorder

☐ Heart Disease / Arrhythmia ☐ High Blood Pressure

☐ High Cholesterol ☐ Autoimmune Disease

☐ Kidney Disease ☐ Liver Disease

☐ Polycystic Ovary Syndrome (PCOS) ☐ Osteoporosis / Bone Loss

☐ Depression / Anxiety ☐ Bipolar Disorder

☐ Epilepsy / Seizures ☐ Sleep Apnea

☐ Asthma / Respiratory Issues ☐ Chronic Pain

☐ HIV / Immunodeficiency ☐ Blood Clotting Disorder

☐ Eating Disorder (past/present) ☐ Adrenal Insufficiency

Please list any other conditions not listed above:

_____

_____

5. Current Medications & Supplements

List ALL prescription medications, over-the-counter drugs, vitamins, and supplements. Omitting this information may result in an unsafe peptide protocol.

Medication / Supplement	Dosage	Frequency	Reason / Condition

Medication / Supplement	Dosage	Frequency	Reason / Condition

6. Hormone & Peptide History

Have you ever used hormone replacement therapy (HRT)? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever used testosterone, estrogen, or other hormone medications? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever used peptides previously? ☐ Yes ☐ No

If yes, please explain: _____

If yes, which peptides and what was your experience?:

_____

_____

Have you ever used anabolic steroids or SARMs? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever been diagnosed with a hormone-related condition? ☐ Yes ☐ No

If yes, please explain: _____

7. Allergies & Adverse Reactions

Do you have any known drug allergies? ☐ Yes ☐ No

If yes, please explain: _____

Do you have any known food allergies? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever had an anaphylactic or severe allergic reaction? ☐ Yes ☐ No

If yes, please explain: _____

Do you have any sensitivities to injections or preservatives (e.g., benzyl alcohol, bacteriostatic water)? ☐ Yes ☐ No

If yes, please explain: _____

8. Lifestyle & Habits

Exercise frequency:

☐ Sedentary (little/none)
☐ 1–2 days/week
☐ 3–4 days/week
☐ 5+ days/week

Diet description:

☐ Standard / Mixed
☐ High Protein
☐ Keto / Low-Carb
☐ Vegan / Vegetarian
☐ Intermittent Fasting
☐ Other

Do you consume alcohol regularly (3+ drinks/week)? ☐ Yes ☐ No

If yes, please explain: _____

Do you use tobacco or nicotine products? ☐ Yes ☐ No

If yes, please explain: _____

Do you use recreational drugs or cannabis? ☐ Yes ☐ No

If yes, please explain: _____

Average hours of sleep per night: _____

Average daily water intake (oz): _____

9. Injection & Administration Preferences

Are you comfortable self-administering subcutaneous injections? ☐ Yes ☐ No

If yes, please explain: _____

Have you received training or instruction on self-injection technique? ☐ Yes ☐ No

If yes, please explain: _____

Preferred injection site (if known):

☐ Abdomen ☐ Thigh

☐ Upper Arm ☐ No Preference

10. Client Certification & Accuracy Statement

I certify that the information provided on this form is complete, accurate, and truthful to the best of my knowledge. I understand that withholding or misrepresenting my medical history may result in an inappropriate peptide protocol and could pose a risk to my health. I release FN Solutions, its owners, staff, and representatives from any liability arising from inaccurate or incomplete information provided on this form.

_____ _____

Client Signature **Date**

_____ _____

Printed Name **Staff Reviewing Form**

FOR STAFF USE ONLY

Recommended Protocol: _____ Contraindications Noted: ☐ Yes ☐ No

Physician Clearance Required: ☐ Yes ☐ No Date Form Received: _____ Client ID: _____

Staff Notes: _____