Medical Intake Summary

Submission ID: j39ZZu9OfFVblHKuZNo0

Patient Profile

PATIENT
Eudes Marquez

DOB
06/24/1967

GENDER
Male

PHONE
4076019052

EMAIL
dario3314m@hotmail.com

ADDRESS
9000 Solay Rd, Winter Garden, FL, USA
2311
Winter Garden, FL 34787

MOTIVATION & CONSENT

How would your life change by losing weight?	I want to improve my energy levels and reduce my risk of developing diabetes like my parents.
Terms of Use / Consents	Yes
State of Residence	TX
Marketing Consent	Yes

VITALS & GOALS

Ideal Weight	165

VITALS & GOALS (CONT.)

Starting Weight	195
Height (feet)	5'9"
BMI	28.8
Pounds to Lose	30 lbs

LIFESTYLE & ACTIVITY

Daily Physical Activity	Sedentary - less than 30 minutes per day
Alcohol Intake	1-2 drinks per week

MEDICAL & MENTAL HEALTH HISTORY

Mental Health Diagnosis	No
Chronic Illness	No
Chronic Diseases History	High blood pressure
Current Conditions	Pre-diabetes
Family History	Diabetes, High blood pressure
Medullary Thyroid Cancer History	No
MEN Type-2 History	No
Gastroparesis History	No

MEDICAL & MENTAL HEALTH HISTORY (CONT.)

Type 2 Diabetes	No
Pregnant or Breastfeeding	No
Surgeries or Procedures	Appendectomy 2015
Blood Pressure	135/85
Weight Loss Procedures	None
Allergies	No

MEDICATIONS & GLP-1 HISTORY

GLP-1 Medication History	No
Side Effects When Starting Medication	N/A
Interested in Personalized Plan for Side Effects	Yes
Current Medications/Supplements	Yes
Medication/Supplement Details	Daily multivitamin, Vitamin D 2000 IU

REFERRAL SOURCE

How did you hear about us?	Google search

ADDITIONAL RESPONSES

First Name	Eudes

ADDITIONAL RESPONSES (CONT.)

Last Name	Marquez
Email	dario3314m@hotmail.com
Phone	4076019052
Date of Birth	1967-06-24
Gender	Male
Address	9000 Solay Rd, Winter Garden, FL, USA
City	Winter Garden
State	FL
Zip Code	34787
Address Line 2	2311

Legal Disclosures & Consents

• Privacy Policy & HIPAA Compliance: I understand my health data is stored securely in accordance with HIPAA regulations and will be used solely for treatment coordination. I acknowledge that my protected health information (PHI) will be shared only with authorized healthcare providers and pharmacy partners involved in my care.

• Weight-Loss Treatment Consent: I authorize EONMEDS and its affiliated medical professionals to review my intake form, laboratory results, vital signs, and medical history to determine candidacy for GLP-1 receptor agonists and adjunct therapies. I understand that treatment recommendations are based on medical evaluation and may be modified or discontinued based on clinical response.

• Telehealth Services Agreement: I consent to receive healthcare services via telehealth technology and understand that these services are subject to the same standards of care as in-person visits. I acknowledge that technical issues may occasionally affect service delivery and that alternative arrangements will be made when necessary.

• Financial Responsibility & Cancellation Policy: I understand that cancellations or rescheduling within 24 hours of scheduled appointments may incur fees up to the full consultation cost. I acknowledge responsibility for all charges not covered by insurance and agree to the payment terms outlined in the financial agreement.

• Informed Consent & Risk Acknowledgment: I have been informed of the potential risks, benefits, and alternatives to GLP-1 therapy. I understand that individual results may vary and that no specific outcome is guaranteed. I agree to report any adverse effects immediately to my healthcare provider.

Digitally signed by

Eudes Marquez

11/23/2025, 7:51:28 PM

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