



Medical Intake Summary

Submission ID: BKGRZvyKQk1FSBSBONi3

Patient Profile

PATIENT

Ricardo Cortez

DOB

06/20/1978

GENDER

Male

PHONE

9567312314

EMAIL

rcortezvilla1@gmail.com

ADDRESS

1526 Ragland Street, Mission, TX, USA

Mission, TX 78572

MOTIVATION & CONSENT

How would your life change by losing weight?

Improving your overall health

Marketing Consent



VITALS & GOALS

Ideal Weight

210

Starting Weight

320

BMI

37.94

Pounds to Lose

110.00

LIFESTYLE & ACTIVITY

| | |
|-------------------------|---|
| Daily Physical Activity | 2 |
|-------------------------|---|

MEDICAL & MENTAL HEALTH HISTORY

| | |
|-----------------|-----|
| Chronic Illness | Yes |
|-----------------|-----|

| | |
|-----------------|----|
| Type 2 Diabetes | No |
|-----------------|----|

| | |
|---------------------------|----|
| Pregnant or Breastfeeding | No |
|---------------------------|----|

| | |
|-------------------------|----------------------------|
| Surgeries or Procedures | Gastric bypass (Roux-en-Y) |
|-------------------------|----------------------------|

| | |
|----------------|----------------------------------|
| Blood Pressure | I don't know the answer to this. |
|----------------|----------------------------------|

REFERRAL SOURCE

| | |
|----------------------------|-----------|
| How did you hear about us? | Instagram |
|----------------------------|-----------|

ADDITIONAL RESPONSES

| | |
|---|-------------------------------------|
| By clicking this box, I acknowledge that I have read, understood, and agree to the Terms of Use, and I acknowledge the Privacy Policy, Informed Telemedicine Consent, and the Cancellation Policy. If you live in Florida, you also accept the Florida Weight Loss Consumer Bill of Rights and the Florida Consent. | <input checked="" type="checkbox"/> |
|---|-------------------------------------|

| | |
|------------------------------|-------|
| Select the state you live in | Texas |
|------------------------------|-------|

| | |
|-----------|---------|
| firstname | Ricardo |
|-----------|---------|

| | |
|----------|--------|
| lastname | Cortez |
|----------|--------|

ADDITIONAL RESPONSES (CONT.)

| | |
|---|---------------------------------------|
| dob | 06/20/1978 |
| 18+ Disclosure : By submitting this form. I certify that I am over 18 years of age and that the date of birth provided in this form is legitimate and it belongs to me. | |
| address | 1526 Ragland Street, Mission, TX, USA |
| Zip Code | 78572 |
| feet | 6 |
| inches | 5 |
| email | rcortezvilla1@gmail.com |
| Phone Number | +1 956 731 2314 |
| gender | Male |
| Have you been diagnosed with any mental health condition? | No |
| What type of chronic condition or illness do you have? | preccion alterial alta |
| Chronic Diseases: Do you have a history of any of the following? | No, none of these |
| Have you been diagnosed with any of the following conditions? | Hypertension |

ADDITIONAL RESPONSES (CONT.)

Have you or any of your family members ever been diagnosed with any of the following conditions?

No, none of these.

Do you have a personal history of medullary thyroid cancer?¹

No

Do you have a personal history of multiple endocrine neoplasia type-2?

No

Do you have a personal history of medullary thyroid cancer?

No

Do you have a personal history of gastroparesis (delayed stomach emptying)?

No

Have you ever undergone any surgeries or medical procedures?

Yes

Are you currently taking, or have you ever taken, a GLP-1 medication?

I have never taken a GLP-1 medication

Do you usually present side effects when starting a new medication?

I don't experience side effects

Would you be interested in your provider considering a personalized treatment plan to help you manage these side effects?

Yes

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

Ricardo Cortez

11/22/2025, 7:15:47 PM

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