



Medical Intake Summary

Submission ID: JwioX6yTXosqd5jCVA1j

Patient Profile

PATIENT

Juliana Vargas

DOB

10/17/2001

GENDER

Female

PHONE

3462816089

EMAIL

vargasna17@gmail.com

ADDRESS

10422 Comanche Springs Ct

Houston, TX 77095

MOTIVATION & CONSENT

How would your life change by losing weight?

Enjoying how your clothes fit, Having more confidence, Getting your energy back, Feeling better about yourself

Terms of Use / Consents

Yes

Marketing Consent

Yes

VITALS & GOALS

Ideal Weight

145

Starting Weight

174

VITALS & GOALS (CONT.)

Height (feet)	5
Height (inches)	7
BMI	27.25

LIFESTYLE & ACTIVITY

Daily Physical Activity	Moderate
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MEDICAL & MENTAL HEALTH HISTORY

Mental Health Diagnosis	No, none of these
Chronic Illness	No, none of the above
Chronic Diseases History	No, none of the above
Current Conditions	No, none of these apply to me
Family History	No, none of these
Medullary Thyroid Cancer History	No
MEN Type-2 History	No
Gastroparesis History	No
Type 2 Diabetes	No
Pregnant or Breastfeeding	No

MEDICAL & MENTAL HEALTH HISTORY (CONT.)

Surgeries or Procedures	No
Blood Pressure	Less than 120/80

MEDICATIONS & GLP-1 HISTORY

GLP-1 Medication History	I have never taken a GLP-1 medication
Side Effects When Starting Medication	Abdominal pain, Decreased appetite, Headaches
Interested in Personalized Plan for Side Effects	Yes

REFERRAL SOURCE

How did you hear about us?	Instagram
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ADDITIONAL RESPONSES

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.	Yes
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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

Juliana Vargas

11/18/2025, 9:03:59 PM

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