Weight Loss Patient Follow Up Form:

Name: _____ **Date:** _____

Have you experienced any problems/issues with the program, medication, or diet? _____

_____

How often do you exercise?

___Very Active; 5-7 days/wk
___Moderate; 3-4 days/wk
___Inactive; rarely or never

How many glasses of water do you drink daily? _____

What does your exercise routine consist of lately? _____

_____

What kind of dieting have you been doing during the last month? Check all that apply:

___Portion control	___Combination Diet	___Low Carb	___Zero Junk/Zero Sugar
___Keto	___High Protein	___Fast Food	___Sweets/Chips
___3 Meals a Day	___4-5 Small Meals a day	___Soda	___Mid-Day Snacking
___Gluten Free	___No Fried Foods	___Energy Drinks	___Late Night Snacking
___Calorie Counting	___Intermittent Fasting		

___Other: _____

Do you have any changes to your insurance, phone number, address, etc? _____

_____

What medication(s) do you need refilled today? _____

_____

Same pharmacy? ___Yes ___No ; _____

Do you have any other questions for the nurse or the doctor? ___No ___Yes;

_____

_____

_____