FOLLOW-UP WEIGHT LOSS VISIT

Name: ______________________________________ Date of Birth: __________ Age: ________

Today's Date: _____________________ Cell phone number: _____________________________

How has your weight loss journey been going? What are your struggles since your last visit?

____

Since your last visit, have you had the following complaints? Check or circle all that apply.

□No problems □Fatigue □Rash □Daytime sleepiness □Vision changes □Dry mouth □Chest pain □Swelling □Palpitations □Irregular heart beat □Fast heart rate □Wheezes □Short of breath □Nausea □Vomiting □Diarrhea □Constipation □Acid reflux □Stomach pain □Frequent urination □Erectile dysfunction □Difficulty urinating □Excessive thirst □Excessive hunger □ Headaches □Numbness/tingling □Dizziness □Tremors □Leg cramping □Joint pain □Difficulty walking □Back pain □Anxious □Sad mood □Suicidal thoughts □Sleep difficulties □Mood swings

List any side effects or conditions you have experienced since your last visit.

____

Name of birth control: ________________ **Are you pregnant?** ___ **Are you breastfeeding**? ___

Last menstrual period: ________________ **Last labs?** ________________

List any new diagnosis, tests, procedures, surgeries and labs since your last visit.

____

List all allergies to food, medications, and environment. What type of reaction do you have?

____

List ALL medications (prescription and non-prescription that you are currently taking.

____

Do you use tobacco/nicotine products? Yes or no Do you consume caffeine? Yes or no

Do you drink alcohol? Yes or no Do **you use or abuse prescription or street drugs?** Yes or no

How times do you exercise per week? _______ How long? (minutes)? ____ Type: ____________________________

Please check or circle all your eating habits and behaviors since your last visit.

□ Eat high fat foods □Wake up hungry □Overeating when alone □No meal planning □No meal packing
□Overeat at social events □Eating too many sweets □Using food as reward □Eating too quickly
□Skips meals □Purge after meals □Uncontrollable binges □Eat out too much □Use laxative or diuretics
□ Eats due to boredom □Drinks high sugary drinks □Eats late at night □Eats large portion sizes
□I do not log my foods □I do not calculate my carbohydrates □I do not weigh myself daily

List the **SPECIFIC** foods you have been eating since last seen. **DO NOT LIST:** meats, veggies, carbs, everything, restaurants, fast food.

Food cravings: ____
Breakfast: ____
Lunch: ____
Dinner: ____
Snacks: ____

Revised 3/8/19