

Today's Date: _____

Patient Name: _____

DOB: _____

Vital Signs: BP: _____ Pulse: _____ Temp: _____ BMI: _____

Weight: _____ Change Since Last Visit (+ / -) _____

Original Weight: _____ Total Change: _____

Assessment:

List Obesity-Related Comorbidities: _____

List Current Medications: _____

Plan/ Goals:

Diet Education Discussed: _____

Activity/ Exercise Prescription Discussed: _____

Behavior/Lifestyle Discussed: _____

Other: _____

Return in _____ weeks for follow-up

Signed: _____

Date: _____