

MEDICALLY SUPERVISED WEIGHT LOSS DOCUMENTATION

Date of Visit: _____

Patient : _____

Date of Birth: _____

Current Weight: _____ Current BMI _____ Weight loss/gained _____

Beginning Weight _____ Blood Pressure _____

List Obesity-Related Comorbidities:

List Current Medications:

Diet Education Discussed:

Exercise/Activity Education Discussed:

List any Behavior/Diet Goals for this patient:
