Weight Management Follow-up Visit OMS follow-up

Name _____ Date _____

Current weight		Medication		BMI	
Initial weight		BP		Body fat %	
Last visit		LMP		Water %	
Change since first visit		*UPT		Resting energy	
Change since last visit					

Please answer the questions below

What **challenges** or **difficulties** are you having with your weight loss? _____

If you are you taking a **medication***, are you finding it helpful? ☐ **yes** ☐ no

Any side effects? ☐ **none** ☐ dry mouth ☐ jitteriness ☐ headache ☐ insomnia ☐ nausea ☐ other _____

Are you able to take the medication as directed? ☐ **yes** ☐ no

If no, what difficulties are you experiencing? _____

Exercise: What type and how often? _____

How well do you **sleep** at night?

☐ through the night ☐ fall asleep easily but can't stay asleep ☐ difficulty falling asleep ☐ frequent or early morning wakening

Are you having any **symptoms** or **physical problems** since starting this program? ☐ **none**

☐ hunger	☐ fatigue	☐ fainting	☐ indigestion	☐ headache	☐ tremors	☐ trouble sleeping
☐ cravings	☐ chest pain	☐ short of breath	☐ joint pain	☐ weakness	☐ depression	☐ hair loss
☐ irritability	☐ rapid heart beat	☐ diarrhea	☐ muscle cramps	☐ numbness	☐ anxiety	☐ cold intolerance
☐ lack of control	☐ fluid retention	☐ constipation	☐ rashes	☐ dizziness	☐ moodiness	☐ irregular periods

Food Diary: Consider WHEN you eat as well as WHAT you eat

- Instead of labeling your meal as "breakfast" please identify your eating events with the time of day
- Focus on 3 meals a day, minimize snacks, eat your larger meal mid-day and your final meal earlier in the evening

time of day	**give me an idea of what you eating in a typical day, including beverages!**

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