



Physician Supervised Weight Loss Documentation

Patient: _____ DOB: _____

Date of Visit: _____ Beginning Weight: _____ lbs.

Current Weight: _____ lbs. BMI: _____ lbs loss/gain: _____

Height: _____ BP: _____ P: _____ R: _____

Obesity related Comorbidites: _____

Current Medications: _____

Physician prescribed diet: _____

Exercise/Activity plan: _____

Behavior Modification goals: _____

Medication changes: _____

Diet changes: _____

Follow-up Plan: _____

Next Appointment: _____

Physician Signature: _____ Date: _____