Weight Management Follow Up Appointment Questionnaire

Please fill out this form prior to seeing the provider for each visit.

Name _____

Nutrition

Are you tracking what you eat? Yes / No **If Yes, How:** Written Journal / App

24-hour diet recall: Please write down exactly what you ate ***yesterday:***

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: (If none, please write "none")

Mid-morning _____

Mid-afternoon _____

Evening _____

Beverages _____

(please list what you are adding to your coffee or other beverages)

How many ounces of water are drinking daily (for reference, one water bottle is 18 oz.)

10-20 oz 40-60 oz 80-100 oz

20-40 oz 60-80 oz 100+ oz

How many meals did you eat out within the last 7 days? (cafeteria, cafe, restaurant, fast food)

0 1 2 3 4 5 6 7 8+

Current Physical Activity (how long and often) _____

Female Patients Only: Form of Birth Control _____

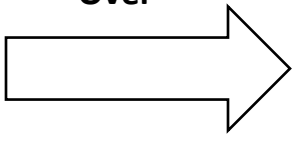
Medication:

Are you taking an appetite suppressant medication? Yes / No

Are you having any side effects or problems with the medication? Yes / No

If yes, please explain _____

Over



Habits/Lifestyle Changes

On a scale of 0-5, 0 being not focused at all to 5 being extremely focused each day. Since your last visit, how focused do you feel you were on your weight loss efforts?

0 1 2 3 4 5

Do you feel like you are struggling with any of the following?

- ☐ Cravings
- ☐ Eating late at night
- ☐ Meal ideas
- ☐ Getting enough protein in
- ☐ Appetite control
- ☐ Not eating enough
- ☐ Not getting results

What dietary habits do you feel you could improve on? Pick 2 things you feel you could focus on this next month.

- ☐ Eating too much in one sitting
- ☐ Snacking throughout the day
- ☐ Snacking in the evening after dinner
- ☐ Keeping a food journal
- ☐ Increasing activity
- ☐ Drinking more water
- ☐ Meal Planning
- ☐ Emotional/Stress eating