Physician Supervised Weight Loss Monthly Progress Note

Patient Name:_____

Date of Birth:_____

Visit Date:_____

Vitals: Height:_____ Weight:_____ BMI:_____

Initial Weight:_____ on _____(date)

Weight loss/gain since last visit:_____ Weight loss/gain since initial visit:_____

Pulse:_____ Blood Pressure:_____

Registered Dietitian/Physician (circle provider) Recommended Weight Loss Program:
Calories/Diet Plan :

☐ 1200-1500 calories	☐ Low Fat
☐ 1800-2000 calories	☐ Carbohydrate Consistent/Diabetic
☐ Other:_____	☐ Other:_____

Activity this week: _____minutes Type of exercise:_____

Behavior Modification discussed	Yes	No (referral to: Dietitian/Exercise Program)
Diet/Activity log reviewed:	Yes	No
Patient Compliant with Weight Loss Plan:	Yes	No
Diet Plan Reviewed:	Yes	No
Activity Plan Reviewed:	Yes	No

New Recommendations:

☐ No Changes	☐ Changes as recommended below:

_____

_____

_____

Physician Signature_____Date/Time_____

Please fax to North Kansas City Hospital Bariatric Center 816-346-7212/ Questions please call 816-691-5048 Opt #4