Sample Physician Monitored Weight Loss Form

Please have your primary care physician complete a form similar to this every month and at the end of the six-month program. Please fax all notes to your patient advocate at 407-303-3821.

Patient Advocate:_____

Date:_____

Patient Name:_____ Date of Birth:_____

Blood Pressure:_____ Temperature:_____

Height:_____Weight: _____

Pounds Lost: _____Pounds Gained:_____

Type of Diet Program (Circle One):

Low Fat Low Carb Low Calorie Jenny Craig Weight Watchers Other:

Type of Exercise (Circle One):

Walk Swim Bike Other:_____

How many times per week is patient exercising?_____

How long each day is patient exercising?_____

Is patient taking any prescription medications to assist in weight loss? Yes No

If yes, please list medication(s):_____

Notes:

_____

_____

_____

_____

_____ _____

Physician Signature Office Phone Number

Print Name or Office Stamp:_____

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