Updated 1.28.15

Weekly Clinic Visit Questionnaire

Name: _____ Date: ____/____/____

1. Did you have any symptoms or physical problems since your last visit? Yes ____ No ____

   If Yes, circle and comment: Light-headedness Headache Cramps Shortness of Breath

   Fatigue/Weakness Hair Loss Constipation Bruising/Bleeding

   Nausea/Vomiting Diarrhea Other _____

   Comments: _____

2. Have you received any other medical care since your last visit? Yes ____ No ____ If Yes, who:
   Reason: _____
3. Any medications taken since your last visit? Yes ____ No ____ If Yes, what:
   (New medications, dosage changes, stopped a medication)

4. Current program? (circle one) Essentials Optifast Individual

   a. Rate your adherence to the plan from 0 to 5: 0 (not on plan at all) 1 2 3 4 5 (no deviations from plan)

   b. How many eating episodes per day? _____

   c. Are you consuming a meal replacement liquid (protein shake)? Yes ____ No ____ What Formula?_____

      If yes, how many each day over the past week? Mon ___ Tues ___ Weds ___ Thurs ___ Fri ___ Sat ___ Sun ___

   d. Are you consuming any nutritional bars (protein bars)? Yes ____ No ____ What brand?_____

      If yes, how many each day over the past week? Mon ___ Tues ___ Weds ___ Thurs ___ Fri ___ Sat ___ Sun ___

5. Did you drink at least 2 additional quarts of non-caloric fluid each day? Yes ____ No ____

6. Do you keep a food journal? Yes _____ No _____
   If yes, how do you track yourself? ____ My Fitness Pal or other electronic food journal ____handwritten

   If yes, how many total calories did you consume over the past week?

   Mon _____ Tues _____ Weds _____ Thurs _____ Fri _____ Sat _____ Sun _____

7. Did you participate in planned exercise this week? Yes ____No ____
8.
   If Yes, how many days? _____ Total number of minutes _____

   How else were you physically active this past week? _____

Patient Signature _____

MEDICAL PROGRESS NOTES

Weight _____Weight Change _____

B/P Sitting _____/Standing _____

Pulse _____ Lab Review Date ___/___/___

By _____