

Medically Supervised Diet and Exercise Program

Patient Name: _____

Date of Visit: _____

Chart #: _____

Date of Birth: _____

Initial Visit Date: _____

Visit Number: _____

Patient is following a:

- | | | |
|--|--|--|
| <input type="checkbox"/> 1200 cal/day diet | <input type="checkbox"/> 1500 cal/day diet | <input type="checkbox"/> 2000 cal/day diet |
| <input type="checkbox"/> Weight Watchers program | <input type="checkbox"/> Atkins diet | <input type="checkbox"/> Nutrisystem diet |
| <input type="checkbox"/> Weight loss pills _____ | | |
| <input type="checkbox"/> Other _____ | | |

Patient is participating in the following exercise regimen:

- | | | |
|---|---|--|
| <input type="checkbox"/> Walking | <input type="checkbox"/> Yoga/Pilates | <input type="checkbox"/> Swimming |
| <input type="checkbox"/> Aerobics | <input type="checkbox"/> Curves | <input type="checkbox"/> Gym/Club membership |
| <input type="checkbox"/> Water aerobics | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> DVD/Video Tapes |
| <input type="checkbox"/> Other: _____ | | |
| <input type="checkbox"/> Pt is unable to exercise due to: _____ | | |

Patient participates in exercise:

- | | | |
|---|---|---|
| <input type="checkbox"/> 0-2 times per week | <input type="checkbox"/> 3-4 times per week | <input type="checkbox"/> 5-7 times per week |
|---|---|---|

Height: _____ Weight: _____ HR _____ B/P _____

Morbid Obesity Super Morbid Obesity

- Change in weight since last visit +/- _____ lbs
- Change in Body Mass Index since last visit +/- _____ %
- Patient verbalized understanding of carbohydrates, fats and protein grams
- Patient keeps a food journal
- Patient keeps an exercise log and documents increase in physical activity
- Patient is disabled and cannot participate in activities of daily living related to obesity
- Patient is compliant with diet and/or exercise

Continue on a:

- | | | |
|---|--|--|
| <input type="checkbox"/> 1200 cal/day diet | <input type="checkbox"/> 1500 cal/day diet | <input type="checkbox"/> 2000 cal/day diet |
| <input type="checkbox"/> Weight Watchers program | <input type="checkbox"/> Atkins diet | <input type="checkbox"/> Nutrisystem diet |
| <input type="checkbox"/> Weight loss pills _____ | | |
| <input type="checkbox"/> Other _____ | | |
| <input type="checkbox"/> Continue exercise | | |
| <input type="checkbox"/> Return to office in 1 month to evaluate progress | | |
| <input type="checkbox"/> Additional behavioral interventions: _____ | | |
| <input type="checkbox"/> Other _____ | | |

Physician Signature