

MEDICALLY MANAGED DOCUMENTATION

Patient Name: _____ DOB: _____

Date: _____ Visit #: _____ Blood Pressure: _____

Weight: _____ Total Weight Loss: _____ BMI: _____

Medical Review:

Dietary Compliance (to be reviewed by MD):

Fluid intake per day _____ (must be at least 64oz/day)

Physical Activity: _____ (goal of 2000 physical activity calories/week)

- Physical Activity Log Checked
- Diet Journal Log Checked

Physician visit notes:

M.D. Signature: _____ Date: _____