# Follow-up Visits

Visit No. _____ Patient's Name: _____

Date: _____ Account No. _____

Are you taking other medications or herbal supplements? ☐ Yes ☐ No [ ] Prescribed [ ] Over-the counter
*If "yes," please list carefully and review with the staff person or nurse*:

**Signs and Symptoms**
Please check any of the following that you have experienced since taking the medications prescribed in this program

| | | | | |
|---|---|---|---|---|
| ☐ Hunger | ☐ Fluid Retention | ☐ Leg Aches | ☐ Light Headed | ☐ Lack of Interest |
| ☐ Vomiting | ☐ Diarrhea | ☐ Chest pain | ☐ Fainting | ☐ Moody |
| ☐ Nausea | ☐ Cravings | ☐ Tremors | ☐ Feeling Weak | ☐ Feeling Spacey |
| ☐ Indigestion | ☐ Numbness | ☐ Dizziness | ☐ Headaches | ☐ Depression |
| ☐ Constipation | ☐ Cold Extremities | ☐ Shortness of Breath | ☐ Rapid Heart Beat | ☐ Difficulty Sleeping |
| ☐ Irritable, Anger | ☐ Lack of Control | ☐ Confused | ☐ Cramps, Gas | ☐ Rashes |

Weight:_____ Gain/Loss: _____ BP: _____ Pulse: _____

Have you had any change in medication(s): ☐ Yes ☐ No
*If "yes," please list the changes:*

Are you eating meals regularly? ☐ Yes ☐ No

Are you eating snacks regularly? ☐ Yes ☐ No

**Current Diet Plan**
☐ Low calorie ☐ Modified low calorie ☐ Ketogenic diet ☐ 1000 calorie ☐ Maintenance

Adherence:
☐ Excellent
☐ Non adherent
Frequency/week: _____

**Exercise**
☐ Strength training ☐ Aerobic/Cardio ☐ Other

Adherence:
☐ Excellent
☐ Non adherent
Frequency/week: _____

**Physical Exam**

Head, Eyes, Ears, Nose and Throat (HEENT): ☐ Normal ☐ JVD ☐ Carotid Bruit

| | | Notes | | Notes |
|---|---|---|---|---|
| **Head** | ☐ Normal | _____ | **Abdomen** | _____ |
| **Eyes** | ☐ Normal | _____ | ☐ Normal | _____ |
| **Nose** | ☐ Normal | _____ | ☐ Ascities | _____ |
| **Throat** | ☐ Normal | _____ | ☐ Hepatomegaly | _____ |
| **Neck** | ☐ Normal | _____ | ☐ Splenomegaly | _____ |
| **Lymph** | ☐ Normal | _____ | ☐ Inguinal Hernia | _____ |
| **Integument** | ☐ Normal | _____ | ☐ Hernia | _____ |
| **Chest** | ☐ Normal | _____ | | |
| **Extremities** | ☐ Normal | _____ | **Cardiac** | |
| **Back** | ☐ Normal | _____ | ☐ Normal | _____ |
| **Neuro** | ☐ Normal | _____ | ☐ RRR without M | _____ |
| **Mental** | ☐ Normal | _____ | ☐ Abnormal | _____ |
| **Status** | ☐ Normal | _____ | | |

**Notes:**

_____
_____
_____

**Review of Symptoms (ROS)**

- ☐ Eyes
- ☐ Ears, Nose, Mouth, Throat
- ☐ Cardio
- ☐ Constitutional, fever, chills, malaise
- ☐ Respiratory
- ☐ GI
- ☐ GU
- ☐ Musco/Skeletal
- ☐ Skin, Allergy, Immune
- ☐ Neuro
- ☐ Psych
- ☐ Endo
- ☐ Heme/Lymph

**Diagnosis**

- ☐ Obesity Type _____
- ☐ Overweight
- ☐ Diabetes
- ☐ Hypertension
- ☐ Hyperlipidemia
- ☐ Sleep Apnea
- ☐ Hypothyroidism
- ☐ Metabolic Syndrome
- ☐ Other: _____

Comments Regarding Diagnosis:

_____
_____
_____
_____
_____
_____
_____
_____
_____

_____
_____
_____

**Treatment Plan**

☐ Low Calorie ☐ Modified Low Calorie ☐ Ketogenic Diet ☐ 1000 calorie ☐ Maintenance

☐ Nutrition Referral

☐ Medications _____ ☐ Rx Written ☐ Dispensed ☐ Other:_____

Exercise Plan: _____

Assessment and Plan Notes:

_____
_____
_____
_____
_____
_____
_____
_____

**Behavioral Therapy**

☐ Zung Depression Score: _____ ☐ Behavior Lesson Modules: _____ ☐ Counseling Referral

**Reviewed:**

☐ Diet/menu
☐ Importance of regular protein intake to regulate appetite and blood sugar
☐ Pathophysiology of metabolic syndrome
☐ Hidden carbohydrates (CHO) sources
☐ Effect of ethyl alcohol (EtOH)
☐ Potential effect of low CHO products on blood sugar/ weight loss efforts in susceptible individuals
☐ Discussed treatment alternatives, desires to attempt metabolic management with dietary prescription.
☐ Individualized menu written with patient participation
☐ Reviewed risk/benefit of treatment with: ☐ Metformin ☐ Anorectic agents ☐ Other

**Labs and diagnosis**

| | | | |
|---|---|---|---|
| ☐ Fasting glucose | _____ | ☐ Hypothyroidism | _____ |
| ☐ Elevated HgbA1C | _____ | ☐ Microalbuminuria | _____ |
| ☐ GTT | _____ | ☐ Total CHO | _____ |
| ☐ Hyperinsulinemia | _____ | ☐ Triglycerides | _____ |
| ☐ Pre-diabetes | _____ | ☐ Low HDL | _____ |
| ☐ Reactive hypoglycemia | _____ | ☐ Elevated HDL | _____ |
| ☐ Elevated hs-CRP | _____ | | |

**Medications**

☐ No changes recommended at this time.
☐ Recommended changes:
- ☐ Appetite not controlled
- ☐ Inadequate weight loss
- ☐ Medication interaction
- ☐ Other: _____

Comments/Plan:

_____

_____

_____

Next Follow-up Visit: _____

**Provider's Signature:** _____