

Weekly Clinic Visit Questionnaire

Name: _____ Date: ___/___/___ Phase: _____ Week: _____

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

If Yes, check 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 this week? Yes ___ No ___ If Yes, who: _____
Reason: _____

3. Any medications taken this week? Yes ___ No ___ If Yes, what: _____
(New medications, dosage changes, stopped a medication)

4. Current dietary plan? _____

a. Did you have problems adhering to the plan? Yes ___ No ___ Comment _____

b. Are you consuming a meal replacement formula? Yes ___ No ___ What Formula? _____
How many packets each day? Mon ___ Tues ___ Weds ___ Thurs ___ Fri ___ Sat ___ Sun ___

c. Are you consuming Nutritional Bars? Yes ___ No ___
How many each day? Mon ___ Tues ___ Weds ___ Thurs ___ Fri ___ Sat ___ Sun ___

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

e. How many calories of food did you consume? (other than formula or nutritional bars) Mon ___ Tues ___ Weds ___ Thurs ___ Fri ___ Sat ___ Sun ___

5. Did you exercise? Yes ___ No ___ If Yes, how many days? _____ Total number of minutes _____

Patient Signature _____

Medical Progress Notes:

DX: _____

Cardio: _____

Neuro: _____

Lungs: _____

Abdomen: _____

Other: _____

Last Week Weight _____ This Week Weight: _____

Weight Change _____ ↓ ↑

B/P Sitting _____/Standing _____

Pulse _____ Lab Review Date ___/___/___

By _____

Lab Work: Normal / Abnormal

Medications: _____

MD Signature: _____