



Patient name: _____ Date of birth: _____

WEIGHT LOSS PROGRAM

Annual Face-to-Face Follow-Up

OFFICE USE · Annual visit

Room # _____ Photo ID verified (DL / ID #) _____ Visit date _____
Weight _____ Height _____ BMI _____ Waist _____ BP _____ HR _____ O2 sat _____

Patients in our weight loss program are seen in the clinic at least once a year. This review helps Dr. Vo decide whether to continue, adjust or stop your treatment. The annual visit fee (\$165) is paid before your appointment is scheduled.

Preferred pharmacy (name and location) _____ Month and year you started the program _____

1. YOUR PROGRESS THIS YEAR

Weight when you started (lbs) _____ Lowest weight this year _____ Current weight at home _____

Current goal weight _____ Waist size now, optional (inches) _____

Have you kept your weight steady for the past 3 months? ☐ Yes ☐ Still losing ☐ Regained some

Overall, how satisfied are you with your progress? ☐ Very ☐ Somewhat ☐ Not satisfied

Biggest change you have made this year _____

2. YOUR MEDICATION

Current weight loss medication and dose _____ How long on this dose _____

Taken as prescribed most of the year? ☐ Yes ☐ Missed some doses ☐ Stopped for a while

If stopped or missed, why? (cost, side effects, supply, other) _____

Side effects you have had this year (check all that apply):

- | | | |
|---|---|--|
| ☐ Nausea or vomiting | ☐ Dizziness | ☐ Mood changes |
| ☐ Diarrhea | ☐ Fast heartbeat | ☐ Injection site reaction |
| ☐ Constipation | ☐ Trouble sleeping | ☐ Gallbladder problem |
| ☐ Heartburn / reflux | ☐ Headache | ☐ Low blood sugar |
| ☐ Stomach pain | ☐ Hair thinning | ☐ None |

Did any side effect lead to an urgent care, ER or hospital visit? ☐ No ☐ Yes



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3. HEALTH CHANGES THIS YEAR

New medical diagnosis? ☐ No ☐ Yes

Surgery, ER visit or hospital stay? ☐ No ☐ Yes

New medications, vitamins or supplements? ☐ No ☐ Yes

Any new heart symptoms (chest pain, palpitations, shortness of breath)? ☐ No ☐ Yes

Pancreatitis, gallbladder problems or severe stomach pain? ☐ No ☐ Yes

Any new family history of medullary thyroid cancer or MEN2? ☐ No ☐ Yes ☐ Not sure

If yes to any of the above, please explain _____

Medication allergies (any new?) _____

4. LIFESTYLE

Meals per day _____ Meals eaten out per week _____ Water per day _____

Alcoholic drinks per week _____ Exercise: type _____ Times per week _____

Tobacco or vaping: ☐ Never ☐ Former ☐ Current

5. SLEEP AND MOOD

Average hours of sleep _____ Sleep quality _____

Snoring or daytime sleepiness? ☐ No ☐ Yes

Over the past 2 weeks, have you often felt down, depressed or hopeless? ☐ No ☐ Yes

Over the past 2 weeks, have you had little interest or pleasure in doing things? ☐ No ☐ Yes

Any thoughts of harming yourself this year? ☐ No ☐ Yes

If you are having thoughts of harming yourself now, please tell our staff today, or call or text 988.

6. WOMEN'S HEALTH

Pregnant, trying to become pregnant, or breastfeeding? ☐ No ☐ Yes ☐ Not applicable

Birth control method _____ First day of last menstrual period _____



ATHENA FAMILY MEDICINE

8301 Lakeview Pkwy, Suite 106, Rowlett, TX 75088 · Phone 469-931-2602 · Fax 469-931-2623

Kevin Vo, MD

Board Certified
Family Medicine

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7. LOOKING AHEAD

What would you like to do next year? ☐ Continue current plan ☐ Adjust dose ☐ Taper off and maintain ☐ Not sure

Your goal for the coming year _____

Questions for Dr. Vo _____

Date of your last physical exam and fasting labs _____

Patient signature Date

OFFICE USE ONLY · Physician review

Weight change since start (lbs / %) _____ Weight change this year (lbs) _____

Labs ordered: ☐ CMP ☐ CBC ☐ Lipid panel ☐ Hemoglobin A1c ☐ TSH ☐ Other: _____

EKG: ☐ Not needed ☐ Done today ☐ Ordered Plan: ☐ Continue ☐ Change dose ☐ Change medication
☐ Taper / stop

Medication and dose for coming year _____ Next annual visit due _____

Notes _____

Physician signature _____ Date _____