



Patient name: _____ Date of birth: _____ Today's date: _____

WEIGHT LOSS PROGRAM: MONTHLY CHECK-IN

Please complete before each monthly visit. Bring it to your appointment or upload it through our patient portal. Please do not email this form.

Monthly fee and refills: after we receive your check-in, our staff will send you an invoice for your monthly assessment fee, which is based on the medication prescribed. Your refill is sent after your check-in is reviewed and the invoice is paid.

This check-in is for: ☐ In-office visit ☐ Patient portal check-in

1. WEIGHT AND MEASUREMENTS

Current weight at home (lbs) _____ Date weighed _____ Weight at last visit, if known (lbs) _____

Waist measurement, optional (inches) _____ Home blood pressure, if you check it _____

Do you weigh yourself at the same time of day, on the same scale? ☐ Yes ☐ No

2. YOUR MEDICATION

Weight loss medication and current dose _____ Day of week / time you take it _____

Have you taken it as prescribed this month? ☐ Yes, every dose ☐ Missed some doses ☐ Stopped taking it

If missed or stopped: how many doses, and why? _____

Do you need a refill or dose change discussed at this visit? ☐ Refill ☐ Dose change ☐ No

3. SIDE EFFECTS SINCE YOUR LAST VISIT

Check any you have had:

- | | | |
|---|---|--|
| ☐ Nausea | ☐ Stomach pain or bloating | ☐ Injection site redness or pain |
| ☐ Vomiting | ☐ Very little appetite | ☐ Hair thinning |
| ☐ Diarrhea | ☐ Headache | ☐ Fast heartbeat |
| ☐ Constipation | ☐ Dizziness or lightheadedness | ☐ Low blood sugar (shaky, sweaty) |
| ☐ Heartburn / reflux | ☐ Fatigue / low energy | ☐ Other: _____ |
| ☐ No side effects | | |

Overall, how bothersome are your side effects? ☐ Mild ☐ Moderate ☐ Severe

Have side effects kept you from eating, drinking enough fluids, or doing daily activities? ☐ No ☐ Yes

Don't wait for your check-in. Call us at 469-931-2602 right away, or go to the emergency room or call 911 after hours, if you have: severe stomach pain that does not go away (with or without pain spreading to your back); vomiting that prevents you from keeping fluids down; signs of dehydration (very dark urine, dizziness when standing); yellowing of your skin or eyes; a lump or swelling in your neck or trouble swallowing; signs of an allergic reaction (swelling of the face or throat, trouble breathing); or new or worsening depression or thoughts of harming yourself.

4. EATING AND NUTRITION

Meals per day _____ Snacks per day _____ Glasses of water per day _____

Are you including protein (meat, fish, eggs, beans, dairy) at most meals? ☐ Usually ☐ Sometimes ☐ Rarely

Hunger and cravings this month: ☐ Much less ☐ A little less ☐ No change ☐ More

Alcohol: ☐ None ☐ 1–3 drinks per week ☐ 4 or more per week



Patient name: _____

5. PHYSICAL ACTIVITY

Type of exercise _____ Minutes per session _____ Days per week _____

Any new pain, injury or physical limitation that affects activity? ☐ No ☐ Yes

If yes, please describe _____

6. SLEEP, ENERGY AND MOOD

Average hours of sleep per night _____ Bedtime / wake time _____

Sleep quality: ☐ Good ☐ Fair ☐ Poor

Snoring, waking up gasping, or daytime sleepiness? ☐ No ☐ Yes

Energy level compared with last month: ☐ Better ☐ Same ☐ Worse

Mood this month: ☐ Good ☐ Some ups and downs ☐ Feeling down or anxious most days

7. HEALTH CHANGES SINCE YOUR LAST VISIT

New medications, vitamins or supplements? ☐ No ☐ Yes

Emergency room visit, hospital stay or new diagnosis? ☐ No ☐ Yes

Changes in blood pressure or blood sugar readings (if you check them)? ☐ No ☐ Yes ☐ Not applicable

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

If yes to any of the above, please explain _____

8. PROGRESS AND GOALS

Biggest success this month _____

Biggest challenge this month _____

My goal for next month _____

Questions for Dr. Vo _____

Patient signature (or typed name if submitted through the portal) _____

Date _____

OFFICE USE ONLY

Weight in office _____ BMI _____ BP _____ Pulse _____ Waist _____

Change since last visit (lbs) _____ Total change since start (lbs) _____

Plan / dose change _____ Reviewed by _____