AFM WEIGHT LOSS EVALUATION

**Reminder**: This packet must be entirely completed in order to have a visit with a provider to discuss initiating weight loss medications. Completion of this packet and scheduling an appointment do not guarantee that weight loss medications will be prescribed. This packet will allow you to have a productive conversation with your provider about nutrition, exercise, and whether or not you are a good candidate for medications that can enhance weight loss.

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| Patient Name: |
| Date of Birth: Today’s Date: |

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| --- | --- |
| **Weight Loss History** | |
| What is your lowest weight in your adult life? |  |
| What is your highest weight in your adult life? |  |
| What is your current weight? |  |
| Have you ever been on weight loss medications before, and if so, which medications? |  |
| If you have been successful with weight loss in the past, what has worked? |  |
| What diets have you tried in the past? |  |

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| **Insurance Information (Must Be Completed for Appointment)**  Some insurances will only cover certain medications while others will not cover weight loss medicines at all. ***Call the number on the back of your insurance card to check coverage*** for the following and place a check mark by the medications that are covered by your current plan. | | | |
| Saxenda [ ] | Contrave [ ] | Wegovy [ ] | Xenical [ ] |

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| **Current Exercise Plan (Type of Exercise, Frequency, Length of Time Spent)** |
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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Please Complete This Diet Log For 1 Week (Including Beverages)** | Snacks |  |  |  |  |  |  |  |
| Dinner |  |  |  |  |  |  |  |
| Lunch |  |  |  |  |  |  |  |
| Breakfast |  |  |  |  |  |  |  |
| Date |  |  |  |  |  |  |  |