Weight Management Virtual Visit

Name _____ Date _____

Your weight _____ Weight loss medication _____

Waist circumference* _____ 1st day of your last period _____

Hip circumference** _____

***Measure your waist:** Stand and place a tape **measure** around your **middle**, just above your hipbones, at the **narrowest point**
****Measure your hips:** Then **measure** the distance around the largest part of your **hips** — the **widest** part of your buttock
Waist-to-hip ratio (WHR): less than 0.85 is "ideal" for women

What **challenges** or difficulties are you having with your weight loss?_____

If you are you taking a **medication***, are you finding it helpful? ☐ **yes** ☐ no ☐ not applicable
Any side effects? ☐ **none** ☐ dry mouth ☐ jitteriness ☐ headache ☐ trouble sleeping ☐ nausea ☐ constipation ☐ other_____
Are you able to take the medication as directed? ☐ **yes** ☐ no
If **no**, what difficulties are you experiencing?_____

Are you following a specific **dietary plan**? ☐ no ☐ Mediterranean ☐ Paleo ☐ Vegan/vegetarian ☐ Ketogenic ☐ other_____
What are your difficulties with your dietary plan?_____

Are you using meal replacements? ☐ **yes** ☐ no
If **yes**, ☐ Full Plan ☐ Fresh Steps ☐ ProLon ☐ purchased product on your own_____

Exercise: What type and how often?_____
If none, what types of movement can you add throughout your day?_____

How well do you **sleep** at night?
☐ through the night ☐ fall asleep easily but can't stay asleep ☐ difficulty falling asleep ☐ frequent or early morning wakening

Are you experiencing any significant **stress**? ☐ **yes** ☐ no
If **yes**, how are you managing? ☐ not at all ☐ meditation practices ☐ exercise ☐ other_____

Are you tracking your food, steps, sleep, mood, etc.? ☐ **yes** ☐ no
If **yes**, ☐ notebook and pen ☐ HealthTrac app ☐ Noom ☐ MyFitnessPal ☐ WW app ☐ other_____
Are you finding it helpful? ☐ **yes** ☐ no

Are you having any **symptoms** or **physical problems** since starting this program? ☐ **none**

☐ hunger	☐ chest pain	☐ nausea	☐ joint pain	☐ numbness	☐ moodiness
☐ cravings	☐ rapid heart beat	☐ bloating	☐ muscle cramps	☐ dizziness	☐ trouble sleeping
☐ irritability	☐ fluid retention	☐ constipation	☐ rashes	☐ tremors	☐ hair loss
☐ lack of control	☐ fainting	☐ diarrhea	☐ headache	☐ depression	☐ cold intolerance
☐ fatigue	☐ short of breath	☐ indigestion	☐ weakness	☐ anxiety	☐ irregular periods

Food Diary: Consider WHEN you eat as well as WHAT you eat

- Instead of labeling your meal as "breakfast", etc. please identify your eating events with the time of day
- Focus on 3 meals a day, minimize snacks, try to eat your larger meal mid-day and your final meal earlier in the evening
- Keep your eating window (first bite of the day to last bite of the day) to a 12–hour time period or less (8-12 hour window)

time of day	**give me an idea of what you eating in a typical day, including beverages!**

Julianne Dunne, MD ⌘ westmed ✉ 3030 Westchester Avenue Suite 202 ★ Purchase, NY 10577 ☎ (914) 848-8668