PRINT SAVE AS EMAIL RESET

Scanning Staff
Doc Type: Questionnaire
Descriptor: WM LCD

Date: _____ /_____ /_____ Week: _____

1. Did you have any symptoms or physical problems since your last visit? ☐ Yes ☐ No
   If Yes, check and comment:

   ☐ Lightheadedness ☐ Headache ☐ Cramps ☐ Shortness of Breath
   ☐ Fatigue/Weakness ☐ Hair Loss ☐ Constipation ☐ Bruising/Bleeding
   ☐ Nausea/Vomiting ☐ Diarrhea ☐ Feeling Faint ☐ Other _____

   Comments: _____
2. Have you received any other medical care this week? ☐ Yes ☐ No
   If Yes, from whom: _____
   Reason: _____
   _____
3. Any changes in medications this week (new medications, dose adjustments, stopped medication)? ☐ Yes ☐ No
   If Yes, which: _____
4. Did you have problems adhering to the plan? ☐ Yes ☐ No
   Comment: _____
   a. Are you eating meal replacement protein shakes? ☐ Yes ☐ No
      Which products? _____
      How many servings each day? Mon _____ Tue _____ Wed _____ Thu _____ Fri _____ Sat _____ Sun _____
   b. Are you eating Nutrition Bars? ☐ Yes ☐ No
      How many each day? Mon _____ Tue _____ Wed _____ Thu _____ Fri _____ Sat _____ Sun _____
   c. Are you eating protein soup? ☐ Yes ☐ No
      How many each day? Mon _____ Tue _____ Wed _____ Thu _____ Fri _____ Sat _____ Sun _____
   d. How many calories of food did you consume other than meal replacement products?
      Mon _____ Tue _____ Wed _____ Thu _____ Fri _____ Sat _____ Sun _____
5. Did you exercise? ☐ Yes ☐ No
   If Yes, how many days? _____ Total number of minutes _____

Patient Signature: _____

Medical Progress Notes

Nurse Signature: _____

Physician Signature: _____

Weight _____ Weight Change _____

B/P Laying _____ /Standing _____

Pulse Laying _____ /Standing _____

Comments:

_____

Allina Health

LOW CALORIE DIET
WEEKLY CLINIC VISIT QUESTIONNAIRE

59-01
Questionnaire

SR-17354 (04/18)

PATIENT LABEL

Patient Name: _____