Oakland Medical Weight Loss

simplifying **Weight Loss®**

6685 Hwy 64 Ste. 2
Oakland, TN 38060
901.465.0250

Follow-up Visit (Injection Patients)

Patient's Name: _____ Date of Birth: _____

Today's Date: _____

Since your last visit, have you started any other medications or herbal preparations?

Prescribed: Yes No Over-the-counter: Yes No

If yes, please list carefully and review with the staff person or nurse:

_____

_____

_____

Have you experienced any of the following signs or symptoms since taking the medications prescribed in this program? Circle all that apply.

Rashes Wheezing Shortness of Breath Heart Palpitations

Patient Signature: _____

— — — — Do Not Fill in Below this Line — — — —

Weight: _____ BMI: _____ Height: _____ (in.) Waist: _____ (in.)

BP:_____ Pulse:_____Gain/Loss: _____

_____M.A. / Inj. Tech.

_____A.N.P. / M.D..

DTH Form PFO 010

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