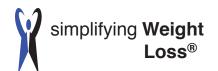
Oakland Medical Weight Loss



6685 Hwy 64 Ste. 2 Oakland, TN 38060 901.465.0250

	FOLLOW-UI	P VISII (INJEC	HON PAHENIS)		
Patient's Name	:	Date of Birth:			
Today's Date:					
Since your last	visit, have you started a	any other medica	ntions or herbal p	reparations?	
Prescribe	ed: Yes No Over-t	he-counter: Yes	No No		
If yes, please li	st carefully and review	with the staff pe	rson or nurse:		
-	rienced any of the followis program? Circle all t		mptoms since tak	ing the medication	ons
Rashes	Wheezing	Shortness of Breath		Heart Palpitations	
Patient Signatu	re:				
DO	NOT FILL IN BELOW	THIS LINE — –	- — —		
Weight:	BMI:	Height:	(in.) Waist:		(in.)
BP:	Pulse:		_Gain/Loss:		
			M	I.A. / Inj. Tech.	
			A	.N.P. / M.D	