

WEIGHT MANAGEMENT

PATIENT PREPARATION FORM

Whether it's your personal medical history, available coverage options, or writing down specific, attainable, short- and long-term goals, this form can help you and your health care team plan for your weight management.

Name _____ Date of Visit _____

Date of Birth _____ Height _____ Weight _____ BMI _____

Please answer these questions as truthfully as possible so together we can develop a personalized weight-loss plan for you.

Do you ever feel like your eating patterns can get out of control? YES NO

Do you eat between meals? YES NO

Do you eat as a response to your emotions? YES NO

Do you have any dietary restrictions? YES NO

Do you currently take part in physical activity? YES NO

Have you been diagnosed with any of the following:

Type 2 diabetes? YES NO

High blood pressure? YES NO

High cholesterol? YES NO

What prescription medications, if any, do you currently take? _____

What kind of foods do you eat? _____

How many times a week do you take part in physical activity? ____ How long do your sessions of physical activity last? _____

What type of physical activity? _____

What are your weight/obesity-management goals?

Short-term goals: _____

Long-term goals: _____

How many serious weight-loss attempts have you made in the past 5 years? 0 1 2 3 4+

Did you participate in any structured weight-loss programs in the past and, if so, which ones?

Was there one program that seemed to work best for you?

What are some barriers that have kept you from losing weight and maintaining weight loss in the past? (eg, nutritional choices, no time for exercise, health issues)

Have you ever been on an anti-obesity or weight-loss medication in the past or are you currently on one? (either over the counter or prescribed) YES NO

If so, which one(s): _____

Current anti-obesity/weight-loss medications: _____

TAKING CONTROL OF YOUR **WEIGHT MANAGEMENT**

Your insurance provider may include weight-management treatments as part of your plan. Contact your carrier or employer for more information about coverage.

Nutritionist/Dietitian

YES NO Co-pay: _____ Sessions: _____

Behavioral therapist

YES NO Co-pay: _____ Sessions: _____

Health Coach

YES NO Provider visit for weight management: _____

Gym membership

Discount YES NO

Reimbursement YES NO

Ask if your place of employment offers a wellness program, which can include:

Smoking cessation program YES NO

Health screenings and wellness assessments YES NO

Stress management education YES NO

Weight-loss program YES NO

Insurance coverage

Does your insurance cover pharmacotherapy for weight loss? YES NO

Does your insurance cover weight-reduction surgeries? YES NO

Follow-up appointment

Date: _____ Time: _____

Office contact information

Name: _____

Phone: _____

E-mail: _____

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Printed in the U.S.A.

US21OB00167

November 2021

