

## Weight Control Prescription

Examinee's name:

◆ Height: \_\_\_\_\_ cm

◆ Waist: \_\_\_\_\_ cm

◆ Weight: \_\_\_\_\_ kg

◆ Body mass index: \_\_\_\_\_ kg/m<sup>2</sup>

1. You are

☐ Normal.

☐ Obese.

☐ Overweight.

2. You have excessive fat around the abdomen.

☐ Yes.

☐ No

3. Because of your weight, your risk level of developing chronic diseases, such as CVDs, hypertension, diabetes, high cholesterol, among others, is

☐ Low.

☐ Normal.

☐ A little increased.

☐ More increased.

☐ Sharply increased.

☐ Very sharply increased.

4. Recommended weight goal:

☐ Not applicable

☐ The primary goal is to lower your current weight by (     )%.

- Your primary target weight is (     ) kg.

- The primary target weight achievement period is (     ) months.

- The weight you need to lose every month is (     ) kg.

5. Prescription to treat obesity

☐ Reduce meal portions.

☐ Reduce snacks or midnight munchies.

☐ Reduce eating out or fast food.

Get (☐ Smoking ☐ Drinking ☐ Exercising ☐ nutrition) prescription

☐ Need to take medication

☐ Others:

6. Health problems or conditions that can be improved if you keep the normal range of weight after weight loss.

☐ Angina pectoris / cardiac infarction

☐ Diabetes

☐ Stroke

☐ High blood pressure

☐ High cholesterol

☐ Peripheral blood vessel disease

☐ Sleep apnea syndrome


☐ Spine or bone problems

☐ Incontinence

☐ Gallbladder stone

☐ Others:

7. Other comments (100 characters or less)

 You need regular clinic visits to assist you in losing weight.

Physician's name/ Signature:

※ This prescription cannot be used for medication. It is only for developing life habits.