Public Health Pharmacist Clinic

A. Weight Management Screening Form Date started……

Name:	**Address:**
Phone Number	
Birth Date	
Emergency Contact/Phone numbers:	

IMMUNIZATION RECORD (Record the date/year of last dose taken, if known)		
TETANUS	FLU VACCINE(S)	**HEPATITIS VACCINE**
PNEUMONIA VACCINE	**ALLERGIES**	**OTHER**

Current medications	**Disease conditions**
	Acute:
	Chronic:

HEIGHT	**WEIGHT**	
Set goals from 1week food diary:		
Eating style:		
The frequency of eating	**size**	**Time of eating**
Environmental factors	**Physical activities / exercises**	
Physical activities / exercises		
Recommendations:		
My intentions		