



PLEASE FILL IN  
AREAS HIGHLIGHTED  
IN GREEN AND  
RETURN

METABOLIC WEIGHTLOSS CLINIC  
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FINDLAY, OH 45840  
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NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

## WEIGHTLOSS TRACKING SHEET

START DATE: \_\_\_\_\_ LAST INJECTION DATE: \_\_\_\_\_ CURRENT WEIGHT: \_\_\_\_\_

STARTING WEIGHT: \_\_\_\_\_ GOAL WEIGHT: \_\_\_\_\_ COMPLETED WEIGHT: \_\_\_\_\_

BLOOD PRESSURE: \_\_\_\_\_ HEART RATE: \_\_\_\_\_  
BP: \_\_\_\_\_ HR: \_\_\_\_\_ COMPLETED BP: \_\_\_\_\_ HR: \_\_\_\_\_

ADVISED CLIENT TO FOLLOW UP W/ PCP

### MEASUREMENTS

CHEST: \_\_\_\_\_ ARM: \_\_\_\_\_ NAVEL: \_\_\_\_\_ HIPS: \_\_\_\_\_ THIGH: \_\_\_\_\_ CALF: \_\_\_\_\_

COMPLETED  
CHEST: \_\_\_\_\_ ARM: \_\_\_\_\_ NAVEL: \_\_\_\_\_ HIPS: \_\_\_\_\_ THIGH: \_\_\_\_\_ CALF: \_\_\_\_\_

YOU MUST CALL OR EMAIL YOUR WEIGHT ON  
SUNDAY EVERY WEEK

WEEK 1	_____ LBS LOST	WEIGHT _____
WEEK 2	_____ LBS LOST	WEIGHT _____
WEEK 3	_____ LBS LOST	WEIGHT _____
WEEK 4	_____ LBS LOST	WEIGHT _____
WEEK 5	_____ LBS LOST	WEIGHT _____
WEEK 6	_____ LBS LOST	WEIGHT _____
WEEK 7	_____ LBS LOST	WEIGHT _____
WEEK 8	_____ LBS LOST	WEIGHT _____

GIVE MON. START WEIGHT ALSO.

HEIGHT: \_\_\_\_\_

BMI: \_\_\_\_\_