

BARTELS MEDICAL ASSOCIATES, PLLC

MEDICAL WEIGHT CONTROL

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NAME: _____

DATE: _____

PLEASE LIST FIVE MEDICAL REASONS WHY YOU MUST LOSE WEIGHT.

1. _____

2. _____

3. _____

4. _____

5. _____

PLEASE LIST FIVE PERSONAL REASONS WHY YOU WISH TO LOSE WEIGHT AND KEEP IT OFF.

1. _____

2. _____

3. _____

4. _____

5. _____