Moaddel Medical

7230 Medical Center Dr, Suite 100, West Hills, CA 91307 · (818) 660-2977

Weight Loss Journal

Patient name: ______________________________ Month / Year: ______________

Starting weight: ____________ **Goal weight:** ______________ **Start date:** ______________

Weigh at the same time of day, on the same scale, in similar clothing. Darker lines separate weeks.

Date	Weight	Waist (optional)	Notes (meals, exercise, how I feel)

Bring this log to your next visit.

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Patient name: ______________________________ Month / Year: ______________

Date	Weight	Waist (optional)	Notes (meals, exercise, how I feel)