

Your weight management conversation starter



Prepare for a productive conversation with your doctor about your weight, health goals and management options. This guide helps you note your thoughts, giving you and your doctor a strong starting point for your weight management journey.

BEFORE YOUR APPOINTMENT:

Reflect and prepare

Please complete the following sections before your appointment to help you and your doctor have a more focused conversation. Your answers will help you both understand why you want to manage your weight, and why this journey is important to you.

YOUR PERSONAL MOTIVATIONS

1 Why is managing your weight important to you? *Tick all that apply.*

- | | | |
|--|---|--|
| <input type="checkbox"/> I want to improve my overall health and well-being | <input type="checkbox"/> I want to reduce the risk of a weight-related health condition (e.g., diabetes, heart disease) | <input type="checkbox"/> I want to improve my self-esteem and body image |
| <input type="checkbox"/> I want to increase my energy levels and physical activity | | <input type="checkbox"/> Other |

→ If you answered other or have any further thoughts, please use the space below:

YOUR WEIGHT MANAGEMENT HISTORY

2 How long have you been concerned about your weight?

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Less than 6 months | <input type="checkbox"/> 6 months to 1 year | <input type="checkbox"/> 1 to 5 years |
| <input type="checkbox"/> More than 5 years | | |

3 What weight management strategies have you tried in the past? *Tick all that apply.*

- | | | |
|--|---|---|
| <input type="checkbox"/> Dietary changes | <input type="checkbox"/> Weight loss medications prescribed by a doctor | <input type="checkbox"/> I haven't tried any weight management strategies |
| <input type="checkbox"/> Increased physical activity | <input type="checkbox"/> Formal weight loss programs | <input type="checkbox"/> Other |
| <input type="checkbox"/> Over-the-counter weight loss supplements (e.g., herbal remedies, appetite suppressants) | <input type="checkbox"/> Bariatric surgery | |

→ If you answered other, please briefly describe the strategies you have tried:

4 If you've lost weight in the past, have you regained it?

- | | | |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> This is my first weight loss attempt |
|------------------------------|-----------------------------|---|

→ If you answered yes, what do you think contributed to the weight regain? *Check all that apply.*

- | | | |
|---|---|---|
| <input type="checkbox"/> I found it difficult to stick to my diet and exercise routine | <input type="checkbox"/> I ate more when I felt stressed or sad | <input type="checkbox"/> I had a health condition or was on a medication that made it harder to lose weight |
| <input type="checkbox"/> I continued to feel hungry and had strong cravings for certain foods | <input type="checkbox"/> I didn't have enough support from family, friends or a support program | <input type="checkbox"/> Other |

→ If you answered other, please briefly describe the reasons:

YOUR HEALTH AND WEIGHT

5 Do you have any of the following health conditions? *Tick all that apply.*

- | | | |
|---|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Liver issues (e.g., fatty liver disease) |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Interrupted breathing during sleep (sleep apnoea) | <input type="checkbox"/> Polycystic ovary syndrome (PCOS) |
| <input type="checkbox"/> High blood sugar (pre-diabetes or type 2 diabetes) | <input type="checkbox"/> Joint pain or arthritis | <input type="checkbox"/> I do not have any other health condition |
| | | <input type="checkbox"/> Other |

→ If you answered other, please briefly describe any other health conditions:

6 Are you currently on any medications that your healthcare professional needs to know about?

- ☐ Yes ☐ No

→ If you answered yes, please list your current medications:

7 How does your weight impact your daily life? *Tick all that apply.*

- | | | |
|---|--|--|
| <input type="checkbox"/> I have difficulty with daily activities, such as walking or bending down to put shoes on | <input type="checkbox"/> I avoid social situations due to concerns about my weight | <input type="checkbox"/> I have difficulty finding clothes that fit me |
| <input type="checkbox"/> I often feel tired and lacking in energy | <input type="checkbox"/> My mood is down, I feel self-conscious and unhappy with my body | <input type="checkbox"/> My weight does not impact my daily life |
| | | <input type="checkbox"/> Other |

→ If you answered other, please briefly describe the ways your weight impacts your life:

YOUR KEY MEASUREMENTS

If you know your body mass index and waist-to-height ratio, please add it here:

→ My body mass index:

→ My waist-to-height ratio:

If you don't know your measurements, scan the QR code to calculate it.



DURING YOUR APPOINTMENT:

Key questions to discuss

Use these questions as a starting point for your conversation with your doctor.

UNDERSTANDING YOUR OPTIONS

What are all the available weight management options for me, considering my health history and goals (e.g., lifestyle changes, medication, surgery)?

What are the pros and cons of each option?

How often will I need to follow up with you?

How do these options work and what results can I realistically expect?

What kind of ongoing support will I receive?

How will I maintain weight loss in the long-term?

→ *Feel free to add your own questions below:*