

DIETARY HISTORY

Patient Name: _____ Current Weight: _____ Height: _____

THIS FORM WILL BE FORWARDED TO YOUR INSURANCE COMPANY AS PART OF THE PREDETERMINED PROCESS. PLEASE BE AS SPECIFIC AS POSSIBLE. PLEASE CHECK AND ANSWER ALL OF THE FOLLOWING.

M.D. SUPERVISED

DIET PROGRAM	# OF ATTEMPTS	WHEN	LENGTH OF TIME	WEIGHT LOSS	WEIGHT GAINED	TIME FRAME
Medi-Fast						
MD Name & Address						
Opti-Fast						
MD Name & Address						
Shots:						
H.C.G.						
B-6						
B-12						
MD Name & Address						
Pills:						
Ionomine						
Amphetamines						
Lasix						
Redux						
Phen-Fen						
Meridia						
Xenical						
MD Name & Address						
Others						

ORGANIZED DIET PLANS

DIET PROGRAM	# OF ATTEMPTS	WHEN	LENGTH OF TIME	WEIGHT LOSS	WEIGHT GAINED	TIME FRAME
Diet Center						
Jenny Craig						
Nutri Systems						
Overeaters Anonymous						
TOPS						
Weight Watchers						
Other						

DIETARY HISTORY

LIQUID DIETS

DIET PROGRAM	# OF ATTEMPTS	WHEN	LENGTH OF TIME	WEIGHT LOSS	WEIGHT GAINED	TIME FRAME
Liquid Protein						
Metracel						
Slim Fast						
Other						

MISCELLANEOUS DIETS

DIET PROGRAM	# OF ATTEMPTS	WHEN	LENGTH OF TIME	WEIGHT LOSS	WEIGHT GAINED	TIME FRAME
Atkins						
Air Force Diet						
Cabbage Soup Diet						
Grapefruit						
Herbal						
High Protein						
Low Calorie						
Low Fat						
Magazine/Book						
Self-imposed fast						
Other						

OVER-THE-COUNTER DIET PILLS

DIET PROGRAM	# OF ATTEMPTS	WHEN	LENGTH OF TIME	WEIGHT LOSS	WEIGHT GAINED	TIME FRAME
Accutrim						
Dexatrim						
Diurex						
Other						

OTHER TYPES OF WEIGHT LOSS

DIET PROGRAM	# OF ATTEMPTS	WHEN	LENGTH OF TIME	WEIGHT LOSS	WEIGHT GAINED	TIME FRAME
Hypnosis						
Acupuncture						
Psychotherapy						
Subliminal Tapes						
Previous Bariatric Surgery						
Other						

EXERCISE

DIET PROGRAM	# OF ATTEMPTS	WHEN	LENGTH OF TIME	WEIGHT LOSS	WEIGHT GAINED	TIME FRAME
Exercise Videos						
Fitness Centers						
Home Equipment						

DIETARY HISTORY

EATING DISORDERS

DIET PROGRAM	# OF ATTEMPTS	WHEN	LENGTH OF TIME	WEIGHT LOSS	WEIGHT GAINED	TIME FRAME
Anorexia						
Bulimia						
Compulsive Overeater						

At what age did you begin your first diet? _____ years

What was your greatest single weight loss? _____ lbs

How long did you sustain that weight loss? _____

How was that weight loss obtained? _____

How many times have you lost over 25 lbs? _____

How long have you been over weight? _____ years _____ months

How long have you been at your current weight? _____ years _____ months

Are you currently under a physician's care for weight loss? Yes ___ No ___
If yes, please fill in your physician name, address and phone number.

Physician Name: _____

Address: _____

Phone #: _____

Patient Signature: _____ Date: _____