SSM Health Weight Management Services
12266 DePaul Drive, Suite 210
St. Louis, Missouri 63044
314-344-6800 Phone
314-622-6453 Fax
ssmweightloss@ssmhealth.com

DIETARY HISTORY

This form will be forwarded to your insurance company as part of the pre-determination process. Please be as specific as possible when you complete this form.

Patient Name _____ Patient DOB _____

Weight History

Current Weight		Weight 1 year ago?
Current Height		Weight in High School?
Heaviest Weight? _____ When? _____		

EATING HABITS

Binge?	☐ Yes ☐ No		Stress?	☐ Yes ☐ No
Purge?	☐ Yes ☐ No		Loneliness?	☐ Yes ☐ No
Boredom?	☐ Yes ☐ No			

Physician Supervised Programs/Attempts

Product/Method	Length of Program	Number of pounds lost	Dates
Medifast			
Optifast			
Redux			
Pondimin			
Fen/Phen			
Phentermine/Fastin/Adipex			
Qysmia/Belviq/Other			
Xenical			
HMR			
Eating Disorder Unit		When	Where
Other			
Physicians name/Address:			

Organized Diet Plans

Product/Method	Length of Program	Number of pounds lost	Dates
American Diabetes Association			
DASH diet			
Jenny Craig			
LA Weight Loss			
Nutrisystem			
Overeaters Anonymous			
TOPS			
Weight Watchers			
Other:			

SSMHealth
Weight Management Services

DIETARY HISTORY

Self Imposed Products/Diets

Product/Method	Length of Program	Number of pounds lost	Dates
Accutrim			
Air Force Diet			
Ali			
Atkins			
Ayds			
Body Solutions			
Cabbage Soup Diet			
Cambridge Diet			
Cortaslim			
Dexatrim			
Diurex			
Grapefruit diet			
Herbal Diet			
Low Calorie Diet			
Low Fat diet			
Relacore			
Richard Simmons Diet			
Scarsdale			
Self-imposed diet			
Slimfast			
Southbeach diet			
Trim Spa			
Other:			

Other Weight Loss Attempts

Product/Method	Length of Program	Number of pounds lost	Dates
Behavior Therapy			
Psychotherapy			
Acupuncture			
Hypnosis			
Fitness Centers			
Exercise programs			
Previous weight loss surgery :			

At what age did you begin your first diet?
Were you considered overweight as a child?
What was your single greatest weight loss?
How long did you sustain that weight loss?

_____ _____

Patient Signature ***Date***

_____ _____

Primary Care Physician Signature (Required) ***Date***

_____

Primary Care Physician Printed Name

SSMHealth
Weight Management Services