

DIETARY HISTORY

Patient Name: _____

Current Weight: _____

PLEASE COMPLETE THE FORM AS PRECISELY AS POSSIBLE

DIET PROGRAMS:	<u># Times Tried</u>	<u>Date(s) Tried</u>	<u>Length Of Time On Diet</u>	<u># Lbs Lost</u>	<u>#Lbs Regained</u>
Example:	3	1990/93/95	2-3 mos ea	5-25 lbs ea	All+

M.D. SUPERVISED

<input type="checkbox"/> Medi-Fast.....	_____	_____	_____	_____	_____
M.D. Name/Address	_____				
<input type="checkbox"/> Opti-Fast.....	_____	_____	_____	_____	_____
M.D. Name/Address	_____				
<input type="checkbox"/> Mayo Clinic.....	_____	_____	_____	_____	_____
<input type="checkbox"/> HMR.....	_____	_____	_____	_____	_____
<input type="checkbox"/> _____	_____	_____	_____	_____	_____

Shots: B-6
 B-12
 Other _____
M.D./Clinic Name _____

Pills: Phen-Fen
 Phentermine (only)
 Fastin
 Redux
 Meridia
 Xenical
 Other _____
M.D./Clinic Name _____

NON M.D. SUPERVISED

<input type="checkbox"/> Weight Watchers.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Nutri-Systems.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Jenny Craig.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Diet Center.....	_____	_____	_____	_____	_____
<input type="checkbox"/> TOPS.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Overeaters Anonymous.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Slimfast.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Sweet Success.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Other:.....	_____	_____	_____	_____	_____

DIET PROGRAMS:

Times
Tried

Date(s)
Tried

Length
Of Time
On Diet

Lbs
Lost

#Lbs
Regained

MISCELLANEOUS DIETS

- Low Calorie Diet.....
- Low Fat Diet.....
- High Protein Diet.....
- Self Imposed Fasts.....
- Atkins Diet.....
- Scarsdale Diet.....
- Pritikin Diet.....
- Richard Simmons.....
- Susan Powter.....
- Herbal Life.....
- Cambridge Diet.....
- Other: _____.....

DIET PILLS (over the counter)

- Accutrim.....
- Dexatrim.....
- Metabolife.....
- Other: _____.....

OTHER TYPES OF WEIGHT LOSS

- Psychotherapy.....
- Acupuncture.....
- Hypnosis.....
- Subliminal Tapes.....
- Other: _____.....

EXERCISE

- Health Club.....
- VCR Tapes.....
- Other: _____.....

How long have you been overweight? _____

Age of first diet? _____

Greatest single weight loss? _____ lbs

How was weight loss obtained? _____

How many times have you lost 25 lbs? _____

Favorite foods/snacks _____

Are you a snacker? Yes No

Favorite snacks _____

Do you eat a lot of sweets? Yes No

How often do you eat sweets? _____

Are you currently under a physicians care for weight loss? Yes No

Type of program _____

Physician Name: _____

Address: _____

Date: _____

Signed: _____