

ST. ALEXIUS NEWSTART 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(please print) _____

WEIGHT HISTORY			
Current weight_____	Height_____	Weight 1 year ago_____	Heaviest weight_____
		Weight in high school_____	When_____

EATING HABITS	YES	NO	
Binge			
Purge			
Stress			
Loneliness			
Boredom			

PHYSICIAN SUPERVISED PROGRAMS/ATTEMPTS	Length of program	Number of pounds lost	Dates
Medifast			
Optifast			
Redux			
Pondimin			
Fen/Phen			
Phentermine/Fastin/Adipex			
Meridia			
Xenical			
HMR			
Other_____			
Physician name/ Address_____			

ORGANIZED DIET PLANS	Length of attempt	Number of pounds lost	Dates
Weight Watchers			
Jenny Craig			
LA Weight Loss			
Nutrisystem			
TOPS			
Overeaters Anonymous			
American Diabetes Association			
Other			

SELF-IMPOSED PRODUCTS/DIETS	Length of attempt	Number of pounds lost	Dates
Slimfast			
Ephedra			
SAH.NEW.001			

SELF-IMPOSED PRODUCTS/DIETS (cont.)	Length of attempt	Number of pounds lost	Dates
Trim Spa			
Accutrim			
Dexatrim			
Cortaslim			
Body Solutions			
Dexatrim			
Diurex			
Relacore			
Alli			
Ayds			
Atkins diet			
Grapefruit diet			
Cabbage Soup diet			
Cambridge diet			
South Beach diet			
Air Force diet			
The Zone diet			
Richard Simmons diet			
Low calorie diet			
Low fat diet			
Herbal diet			
Self-imposed fast			
Other_____			

OTHER WEIGHT LOSS ATTEMPTS	Length of attempt	Number of pounds lost	Dates
Behavior therapy			
Psychotherapy			
Acupuncture			
Hypnosis			
Fitness centers			
Exercise programs			
Previous weight loss surgery			
Type_____			

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?	
Are you a snacker? If yes, how many times per day?	
What is your favorite snack?	

Patient Signature _____ Date _____