



CENTER FOR WEIGHT MANAGEMENT

HORIZON HEALTH

Nutrition Dietary History

**Please complete prior to your first visit with the dietitian*

Patient Name: _____ Current Weight: _____ Height: _____ Goal weight _____ How long have you been overweight: _____

Your age at first diet: _____ Heaviest Weight: _____ Greatest single weight loss: _____

How was weight loss obtained: _____

Favorite foods: _____ Are you a snacker: Yes _____ No _____ Details: _____

Do you eat sweets: Yes _____ No _____ Details: _____

Who does the cooking: _____ Who does the grocery Shopping: _____

How many meals per week do you eat out or away from home: _____ Restaurants: _____

What do you drink for beverages on an average day: Morning _____ Afternoon _____ Evening _____

Do you drink alcohol Yes _____ No _____ How much: _____

Explain current amount of exercise or activity in an average day: _____

Physical Limitations: _____

Current challenges to improving my health include:

- | | |
|-----------------------|-----------------------------------|
| a. Lack of time | f. Family responsibility |
| b. Lack of motivation | g. Illness or physical limitation |
| c. Work Schedule | h. Traveling for work, etc |
| d. Too expensive | i. Other _____ |
| e. Social Calendar | |

How do you feel about making behavioral changes:

- a. Ready to start making changes now
- b. Ready to think about making changes
- c. Not ready to make any changes to my current lifestyle

Current use of nicotine: (i.e. Cigarettes/e-cigarettes/cigars/pipes/chewing tobacco/nicotine gums or patches)

Type: _____ **Frequency/Amount:** _____

Are you on dialysis? _____ **Renal Dietitian contact info:** _____

PROGRAM: Please fill out the details for each row (program or diet) you have tried in the past. This helps us to obtain authorization for your surgery as many insurances require a diet history of failed diet attempts in order to provide approval for you to have surgery.	# Times Tried	Dates Tried	Length of Time Tried	# Lbs. Lost	# Lbs. Regained
MD SUPERVISED: (list name & addr. of dr. below)					
Medifast					
Opti-Fast					
Registered Dietician visits					
SHOTS: (B-6, B-12, OTHER, PLEASE SPECIFY):					
Other:					
PILLS:					
Phen- Fen					
Phentermine (only)					
Fastin					
Redux					
Meridia					
Xenical					
Other pills (specify):					
NON-MD SUPERVISED DIETS:					
Weight Watchers					
Nutri-Systems					
Jenny Craig					

Diet Center					
TOPS					
Overeaters Anonymous					
Slimfast					
Sweet Success					
Other:					
DIET PROGRAMS:					
Low Calorie Diet					
Low Fat Diet					
High Protein Diet					
Self Imposed Fast					
Atkins Diet					
Scarsdale Diet					
Richard Simmons diet					
Herbal Life					
Other:					
DIET PILLS, OVER THE COUNTER:					
Accutrim					
Dexatrim					
Metabolife					
Other:					
OTHER TYPES OF WEIGHT LOSS ATTEMPTS:					
Psychotherapy					
Acupuncture					
Hypnosis					
Subliminal Tapes					
Other:					
EXERCISE:					
Health Clubs (specify):					
CD / VCR Tapes: (specify types):					
Other:					

Patient's Signature

Date