PRE-OPERATIVE DIET HISTORY

This form is to be completed by your primary care physician. This diet history will be submitted to your insurance company along with medical clearances, to determine approval for Bariatric surgery.

INITIAL ASSESSMENT / VISIT 1:

DATE: _____

PATIENT'S NAME: _____

DOB: _____ GENDER: M F

HEIGHT: _____ WEIGHT: _____

The above named patient has been under my care. Based on diagnostic terminology they are morbidly obese, and, are a candidate for Bariatric surgery. Numerous attempts in the past with more conservative weight loss methods have been unsuccessful. The patient is aware of the need for a multidisciplinary regimen prior to surgery.

M.D. SIGNATURE: _____

VISIT 2:

DATE: _____

WEIGHT: _____ LOSS/GAIN: _____

TOTAL AMOUNT: _____

PLAN: Monthly Follow-up

MD SIGNATURE: _____

VISIT 3:

DATE: _____

WEIGHT: _____ LOSS/GAIN: _____

TOTAL AMOUNT: _____

PLAN: Monthly Follow-up

MD SIGNATURE: _____

VISIT 4:

DATE: _____

WEIGHT: _____ LOSS/GAIN: _____

TOTAL AMOUNT: _____

PLAN: Monthly Follow-up

MD SIGNATURE: _____

VISIT 5:

DATE: _____

WEIGHT: _____ LOSS/GAIN: _____

TOTAL AMOUNT: _____

PLAN: Monthly Follow-up

MD SIGNATURE: _____

VISIT 6:

DATE: _____

WEIGHT: _____ LOSS/GAIN: _____

TOTAL AMOUNT: _____

PLAN: Monthly Follow-up

MD SIGNATURE: _____

NOTES:

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