

Surgical Associates of Metro Atlanta, LLC

20 Year Diet Weight Loss Program History Worksheet

Please complete as accurately as possible prior to your first appointment. Please use back of this form if additional space is needed.

Patient Name _____ **Date of Birth** _____

DIET/PROGRAM NAME	YEAR	HOW LONG	WEIGHT LOSS	WEIGHT RE-GAIN	DIET/PROGRAM COST
<input type="checkbox"/> Jenny Craig/Weight Watchers					
<input type="checkbox"/> NutriSystem/Quick Weight Loss Ctr.					
<input type="checkbox"/> Atkins Diet/South Beach Diet					
<input type="checkbox"/> Slim Fast/ OptiFast					
<input type="checkbox"/> Cabbage Soup Diet/Grapefruit Diet					
<input type="checkbox"/> Dexatrim/Metabolife					
<input type="checkbox"/> Xenedrine/Phenterimine					
<input type="checkbox"/> Low Carb. Diet/Low Fat Diet					
<input type="checkbox"/> Richard Simmons					
<input type="checkbox"/> MD Supervised # _____ Calorie Diet					
<input type="checkbox"/> Fasting/Decrease Eating					
<input type="checkbox"/> Over Eaters Anonymous					
<input type="checkbox"/> Other					
<input type="checkbox"/> Other					
<input type="checkbox"/> Other					

WEIGHT AT EACH AGE LISTED BELOW

12	18	25	30	35	40	45	50
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