Preoperative Physician Supervised

Bariatric Surgery Diet/Weight Loss Documentation

Patient Name: ____________________________
DOB: ____________________________
Date of Service: ____________________________

Diet Form / Visit # ________

Initial Weight __________ **Current Weight___________**
Weight Loss this past month: ______________

Progress Towards Goals:

____
____
____

Patient concerns voiced:

____
____

24 Hour Recall of Caloric Intake:
Breakfast: ____
Lunch: ____
Dinner: ____
Snacks: ____

Exercise progress and reviewed goals:

____
____
____
____

Recommendations:

____
____
____
____

Follow – up: 1 MONTH

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Physician Signature

Cc: Hamot Bariatric Surgery Center
Fax: 814-877-6356