SURGICAL ASSOCIATES

AtlantiCare

Physician Group

Diet History

Physician Supervised?	Type of Diet	Start date	End Date	Start Weight	End Weight	Weight 6 months Later	Total Weight Loss	Total Weight Regain	Comments

2009_____ 2010 _____ 2011 _____ 2012 _____ 2013 _____ 2014 _____

Please fill out the diet history above. There must be at least five diets listed that you have tried and at least one of those must have been within the past 5 years. On the numbered lines please list your highest weight of those years.

Name _____ Date _____