

*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

Physician Signature

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