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Medically Supervised Weight Loss

(**ASC staff only**) Current Weight:_________ Height: _______ BMI: _____________

(**ASC staff only**) Initial Weight: _________ Total Weight Change: (+ / -) ________________

Patient Name: ________________________ **DOB**: _____________ **PEIA**: Y / N Date:__________

Please circle where you are currently with each healthy habit.

1- Do you stop eating before the feeling of fullness?	Never	Sometimes	Always
2- Eat 1 teaspoon slowly; chew thoroughly; analyze fullness.	Never	Sometimes	Always
3- Portion control (all servings fit into the palm of your hand).	Never	Sometimes	Always
4- Avoid grazing/mindless eating (boredom or late at night).	Never	Sometimes	Always
5- Limit eating out & selecting low calorie options when doing so.	Never	Sometimes	Always
6- Avoid high calorie beverages (soda, fruit juice, sugar sweetened)	Never	Sometimes	Always
7- Drink fluids between meals (not with meals).	Never	Sometimes	Always
8- Drink 50-60 ounces of water daily.	Never	Sometimes	Always
9- All beverages are caffeine free.	Never	Sometimes	Always
10- All beverages are carbonation free.	Never	Sometimes	Always
11- Avoid simple sugars (cookies, bread, ice cream, fruit juice)	Never	Sometimes	Always
12- Practice healthier cooking methods: bake, steam, grill.	Never	Sometimes	Always
13- Include lean meats (90/10 or 80/20) hamburger, egg whites, fish, skinless chicken/turkey, tuna in water, tofu)	Never	Sometimes	Always
14- Only consume whole grain pastas, breads, rice	Never	Sometimes	Always
15- Try to eliminate: fried foods, fats (butters), and vegetable oil.	Never	Sometimes	Always

16- ___ Non-smoker; ___ Previous smoker (Stop date: _________); ___ Smoker (Years: ___)

(You must be at least 6 weeks nicotine free before surgery)

17.What is your daily caloric intake? ____________

18. Do you regularly food journal? Y/N (Please start, if not) If YES, paper or a phone app? ___________

19. Type of exercise? _______________________ * Days/week? ____ * Duration? (how long) _________

Patient Signature: ______________________Nutritionist/Dietician: ______________________

Physician signature: _____________________ (Please have **MD/DO** sign; required by insurance)

Akkary Surgery Center staff use only: ____ (Check mark if **seminar** date)