Bariatric Patient Nutrition & Lifestyle History

Name ____________________________ Date ____________________

Patient ID # ______________________ 5% goal weight _____________

What Bariatric procedure are you considering? Bypass (RNY) Sleeve

Weight History

Current weight: _____________ lbs.

What has been your highest adult weight? _____________ lbs.

What is your desired goal weight at 12 - 18 months after surgery? ______________ lbs.

How long have you struggled with your weight?

   childhood    adolescent    teenager    entire life    # _____ years

What current health problems do you have that can possibly improve with weight loss?
(i.e. diabetes, sleep apnea, knee pain)

What are you most looking forward to with the weight loss?
(i.e. have more energy, get off meds, play with kids, travel)

What do you think is the reason(s) for your difficulty in losing and maintaining your weight?

   _____ overeating
   _____ poor eating habits
   _____ emotional eating
   _____ lack of exercise
   _____ stress
   _____ injury
   _____ heredity
   _____ marriage
   _____ pregnancy
   _____ divorce
   _____ quit smoking
   _____ other, explain:
Were there any specific event(s) that lead to significant weight gain?  Yes / No
If yes, explain.  (i.e. loss of a loved one, injury, trauma, illness, job loss)

When you lost weight in the past, how many pounds did you lose on average with each attempt?  ______________ lbs.

Greatest single weight loss: ________ lbs.  Weight loss sustained for: ________months/years

What made this your most successful weight loss?
  structured food plan  exercise
  accountability  food records
  vegetables & fruits  other __________________________

Diet Assessment

How many meals per day do you typically eat?

What meal(s) do you usually skip? (circle all that apply)
  breakfast  lunch  dinner

How many days a week do you usually skip this meal?

Where are most of your meals eaten?
  home  work  car  restaurant  other ____________

How often do you eat out?  Number of times ____________ per week/per month (circle one)

What type of restaurants?  (i.e. fast food, take out, diner, full service restaurant, Italian)

Who does the majority of cooking in your home?

Are they/you willing to change how they prepare food to make healthy meals?  Yes / No
What size and type of meals do you eat? (circle all that apply)

- medium portion
- large portion
- extra-large

- high fat
- high carbohydrate
- high sugar

Taste preference: sweets, salty foods or both?

How often do you snack? (circle all that apply)

- morning
- afternoon
- evening
- between all meals
- graze all day

Snacks foods: (circle all that apply)

- chips
- nuts
- fruit
- cake
- popcorn
- bread
- chocolate
- donuts
- crackers
- pasties
- candy
- ice cream
- baked goods
- cheese
- cookies
- Other _______________

**Fluids:** how many fluids do you drink each day? Mark how many ounces you drink each day.

<table>
<thead>
<tr>
<th>fluid</th>
<th>oz/day</th>
<th>fluid</th>
<th>oz/day</th>
</tr>
</thead>
<tbody>
<tr>
<td>water</td>
<td></td>
<td>diet soda</td>
<td></td>
</tr>
<tr>
<td>flavored water</td>
<td></td>
<td>soda</td>
<td></td>
</tr>
<tr>
<td>Crystal Light</td>
<td></td>
<td>regular tea</td>
<td></td>
</tr>
<tr>
<td>sports drink</td>
<td></td>
<td>decaf tea</td>
<td></td>
</tr>
<tr>
<td>energy drink</td>
<td></td>
<td>green tea</td>
<td></td>
</tr>
<tr>
<td>skim or 1% milk</td>
<td></td>
<td>herbal tea</td>
<td></td>
</tr>
<tr>
<td>2% milk</td>
<td></td>
<td>sweetened tea</td>
<td></td>
</tr>
<tr>
<td>whole milk</td>
<td></td>
<td>regular coffee</td>
<td></td>
</tr>
<tr>
<td>almond milk</td>
<td></td>
<td>decaf coffee</td>
<td></td>
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<tr>
<td>juice (i.e. apple, orange, grape, etc.)</td>
<td></td>
<td>elaborate coffee - “Starbucks style”</td>
<td></td>
</tr>
<tr>
<td>other</td>
<td></td>
<td>Total fluids per day:</td>
<td></td>
</tr>
</tbody>
</table>
**Alcohol:** do you drink alcohol?  Yes / No / Sometimes / I never drink alcohol

If yes:  wine, beer, hard alcohol, mixed drinks, other _______________________

# of drinks: ________________________  How often: ________ per week / month/ year

Do you have any dietary restrictions or food allergies?  Yes / No  If yes, what?  
(*i.e. lactose intolerant, gluten free*)

Are there any foods, *proteins in particular*, you dislike?

**Eating Habits:** How would you describe your eating habits?

_____ distracted eating (in front of TV, computer, iPad, phone)
_____ eat in car
_____ eat in a rush
_____ skip meals
_____ feel guilty after overeating
_____ graze throughout the day
_____ eat large amounts of food thru out day
_____ eat until uncomfortably full
_____ “closet” eating so no one sees you
_____ eat healthy during day but overeat in evening
_____ eat in the middle of the night

What triggers you to eat?

_____ stress
_____ tired
_____ boredom
_____ depressed
_____ anxiety
_____ comfort
_____ self-reward
_____ sadness
_____ anger

_____ loneliness
_____ happy
_____ hunger
_____ availability of food
_____ lack of hunger/fullness awareness
_____ social situations
_____ external cues
_____ PMS
_____ other
Physical Activity History

Type and frequency of physical activity done in last 30 days:

Type of activity ___________________ Length of time_________________ Days per week_____________

Type of activity ___________________ Length of time_________________ Days per week_____________

Do you have any physical limitations? Yes / No

If yes, explain:

Vitamins/Supplements (circle all that apply)

- Multivitamin
- Calcium
- Probiotic
- Vitamin D3
- Iron
- Vitamin C
- Fish oil
- Biotin
- Co Q10
- Other ________________________ I don’t take any vitamins

Tobacco/Marijuana

Have you ever smoked or used tobacco products? Yes / No

If yes, what type, amount/day:

If quit, when? Date of last puff?

Do you use marijuana?

If yes, what type and how often?
Stress

Stress level of job:  1 = low  5 = moderate  10 = high

1 2 3 4 5 6 7 8 9 10

Stress level of personal life:  1 = low  5 = moderate  10 = high

1 2 3 4 5 6 7 8 9 10

How do you manage the daily stress in your life? (i.e. walk, deep breathing, read)

Support system

Who is supportive of your decision to have Bariatric surgery and make permanent lifestyle changes? (i.e. spouse/partner, family, friends, coworkers)

What type of support works best for you? (i.e. go for walks with you, help with cooking, lend an ear, encouragement)

Occupation: Days/Hours:

Commute time: ________________ minutes each way