

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

high fat

large portion

high carbohydrate

extra-large

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.

fluid	oz/day	fluid	oz/day
water		diet soda	
flavored water		soda	
Crystal Light		regular tea	
sports drink		decaf tea	
energy drink		green tea	
skim or 1% milk		herbal tea	
2% milk		sweetened tea	
whole milk		regular coffee	
almond milk		decaf coffee	
juice (<i>i.e. apple, orange, grape, etc.</i>)		elaborate coffee - "Starbucks style"	
other		Total fluids per day:	

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 | _____ loneliness |
| _____ tired | _____ happy |
| _____ boredom | _____ hunger |
| _____ depressed | _____ availability of food |
| _____ anxiety | _____ lack of hunger/fullness awareness |
| _____ comfort | _____ social situations |
| _____ self-reward | _____ external cues |
| _____ sadness | _____ PMS |
| _____ anger | _____ 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