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.e. apple, orange, grape, etc.)*		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, <u>proteins in particular</u>, 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