**WVU Bariatrics**
**A Comprehensive Surgical Weight Loss Program**

**Nutrition Questionnaire**

Name**:** ______________________________ Preferred Name**:** _________________________

Date of Birth: ____________ Age: ______ Sex: □ Male □ Female

**For Women:** Do you have plans for a future pregnancy? □ Yes □ No □ Maybe/Unsure

**For Women, are you**: □ Premenopause □ Perimenopause □ Postmenopause □ History of hysterectomy

**Weight History**:

Are you currently at your highest weight: □ Yes □ No
**If no**, what has been your highest weight: ______ Age at that weight: ______
Weight 1 year ago: ______ (lb) Lowest adult weight ______ (lb) Age at that weight ______

Amount of weight loss you hope to see with surgery: ______ Your ideal weight following surgery: ______

How would you describe your weight throughout your life? Please circle.

| | | | |
|---|---|---|---|
| Young Child: | Underweight | Normal Weight | Overweight |
| Grade School: | Underweight | Normal Weight | Overweight |
| High School: | Underweight | Normal Weight | Overweight |
| 18 – 35 years old: | Underweight | Normal Weight | Overweight |
| 35+ yeas old: | Underweight | Normal Weight | Overweight |

Briefly describe your weight history; has weight gain/loss been gradual, any periods of significant weight gain/loss, long periods of stable weight without gain/loss, or factors that have impacted your weight?:

_______________________________________________________________________________

_______________________________________________________________________________

Why seeking bariatric surgery at this time/Motivation for wanting surgery?

_______________________________________________________________________________

_______________________________________________________________________________

**Diet and Weight loss attempts:**

1. Are you currently on a diet for a medical reason? □ Yes □ No

If yes, please describe:

_______________________________________________________________________________

_______________________________________________________________________________

2. Are you currently or have you in the past worked with a Dietitian, Diabetes Educator, or Physician on diet or Weight loss: □ Yes □ No If yes, please describe when, for how long and what you did:

_______________________________________________________________________________

_______________________________________________________________________________

3. Are you currently or in the past used prescription or over the counter weight medication such as: Merida, Orlistat (Xenical), Qsymia, Belviq, Fen Phen, Adipex, Alli, HCG injections; Dexatrim, Trim Spa, Metabolife, Stacker III, etc. □ **Yes** □ **No** **If yes,** please list below.

| Name of medication | Year used | Length of time | Pounds lost |
|---|---|---|---|
| | | | |
| | | | |

**Please list all previous weight loss attempts not already listed:**

Weight loss attempts may include things you've done on your own or part of a structured program such as: Self modifying diet, self-monitoring, diet and exercise, ChooseMyPlate, Food Pyramid, nutrition classes, Weight Watchers, Jenny Craig, Overeaters Anonymous, Atkins, NutriSystem, Optifast, HMR, etc.

| Name of diet | Year | Length of time | Pounds lost |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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**Food Preferences/tolerances:**

Do you have any food intolerances? □ Yes □ No **If yes,** please list: ______________________________

Do you have any food allergies? □ Yes □ No **If yes,** please list: ______________________________

List any personal, religious, cultural, ethnic practices or restrictions that affect your health care of diet:

______________________________________________________________________________

Are you a picky eater? □ Yes □ No Do you enjoy a variety of foods/trying new things? □ Yes □ No

List foods that you especially dislike:______________________________________________________

List your favorite foods: ______________________________________________________________

Any problems with the following: Check all that apply.

□ diarrhea □ heartburn □ nausea/vomiting □ constipation □ swallowing problems

□ chewing difficulties □ poor teeth/ill-fitting dentures □ No teeth/no dentures

□ dry or sore mouth/throat □ recent change in taste or appetite

**Supplements:**

1. Do you currently take any **Vitamin or Mineral Supplements**? □ Yes □ No

**If yes,** please list name and amount taken:_______________________________________________

2. Do you use any other **Dietary or Herbal Supplements** on a regular basis? This would include things like fiber tablets or powder, garlic pills, fish oil, etc. □ Yes □ No **If yes,** please list supplements and amounts: ________________________________________________

3. Do you use any Meal Replacement Products (liquids, bars, etc.)? □ Yes □ No

**If yes,** please list brand and how often: ________________________________________________

Please list the people in your household and their relationship to you: ______________________________

________________________________________________________________________

Who does your grocery shopping: □ Self If not, please list: ______________________________

Who does the cooking: □ Self If not, please list: ________________________________________

Are you on a limited food budget or rely on food stamps, food pantry, or similar for food:

□ Yes □ No **If yes,** please describe: ________________________________________________

Do you feel you have a support system in place as you go through surgery: □ Yes □ No

**If yes,** please list who your primary support person(s) are: ______________________________

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**Daily Activities:**

Average hours of sleep per night: ________ Is your sleep restful? □ Yes □ No

How would you rate your daily stress level?

□ Not at all/somewhat stressed □ Moderately stressed □ Very stressed

What things/techniques do you use to manage or reduce stress? ______________________________

How often do you find yourself eating in response to stress, emotions, boredom (in the last 6 months)?

□ Never/less than once/month □ 1-3/month □ 1/week □ 2-4/week □ 5+/week

List any specific foods you have at this time:________________________________________________

**Review of Physical Activity and Limitations:**

Do you participate in regular exercise (walking, biking, swimming, etc.)? □ Yes □ No

**If yes,** type: Frequency/Duration: ________ time(s) per week, for ________ minutes.

If any activity limitations, please describe:

________________________________________________________________________

________________________________________________________________________

How would you describe your activity during a typical day at work or home?

□ Unable to stand or walk by one's self for greater than 15 minutes without pain/need to sit

□ Sedentary (sitting most of the day)

□ Active (standing most of the day)

□ Very active (walking most of the day)

What plans do you have for increase physical activity currently and after surgery?

________________________________________________________________________

________________________________________________________________________

**Eating Habits**

1. How many times do you eat in a day (on average)?

□ Once □ 2-3 Times □ 4-6 Times □ 7+ Times □ 2-3 Times □ No routine - varies

2. Does your meal routine change greatly from weekdays to weekends **or** work days to non-work days:

□ Yes □ No **If yes,** please describe:______________________________________________

______________________________________________________________________

3. How often do you skip meals: □ Rarely □ 2-3 Times/week □ 4-6 Times/ week □ Daily

4. Do you often snack, nibble or graze throughout the day: □ Yes □ No

**If yes,** describe snack: ______________________________________________

5. How long do your meals typically last?

□ 5 minutes or less □ 5-15 minutes □ 20-30 minutes □ 30 minutes or more

6. How often do you feel uncomfortably full after eating

□ Every meal/daily □ 1-6 times/week □ couple times a month □ less than once a month

7. Where do you typically eat? □ Table □ In front of the TV □ Office □ Car /On the go □ Other _________

8. With whom do you typically eat? □ Alone □ With spouse/partner/family/friends/coworkers

9. Meals consumed or prepared away from home (including fast food, sit down, carry out, cafeteria):

□ /day □ /week □ /Month

Where (list typical choice)?______________________________________________

10. How often do you consume convenient foods such as: ready-made, boxed meals, frozen entrée

□ /day □ /week □ /Month

Please List examples:______________________________________________

11. How many servings of fruits or vegetables combined/day are you eating?

□ 1 serving or less □ 2-3 servings □ 4-5 servings □ Greater than 5 servings

Please list common choices: ______________________________________________

______________________________________________________________________

12. How often do you consume sweets (candy, cookies, cake, etc)?

□ /day □ /week □ /Month

List any specific sweets you eat:______________________________________________

**Beverages**

How much of the following do you drink on an average **DAY**?

| | | | | |
|---|---|---|---|---|
| Juice | □ None | □ 1-2 servings | □ 3-5 servings | □ 6+ servings |
| Regular soda | □ None | □ 1-2 servings | □ 3-5 servings | □ 6+ servings |
| Diet soda | □ None | □ 1-2 servings | □ 3-5 servings | □ 6+ servings |
| Unsweet/sweet tea | □ None | □ 1-2 servings | □ 3-5 servings | □ 6+ servings |
| Coffee | □ None | □ 1-2 servings | □ 3-5 servings | □ 6+ servings |
| Milk | □ None | □ 1-2 servings | □ 3-5 servings | □ 6+ servings |
| Water | □ None | □ 1-2 servings | □ 3-5 servings | □ 6+ servings |

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**Alcohol Use**

How often do you have a drink containing alcohol?

□ Never □ Monthly or less □ 2-4 x/month □ 2-4 x/week □ 4 x/week or more

How many drinks containing alcohol do you have on a typical day when you are drinking?

□ 1-2 □ 3-4 □ 5-6 □ 7-9 □ 10 or more

**Tobacco Use**

Do you currently use one or more tobacco products? □ Yes □ No

Which tobacco products do you currently use? Check all that apply.

□ None (I do not use tobacco products) □ Cigarettes □ Smokeless tobacco (spit/chew/snus/dip)

□ Cigars, cigarillos, or little cigars □ Pipe □ E-cigarettes

If yes, how much per day?________________________________________

Are you aware of tobacco cessation services that are available? □ Yes □ No

**If no,** have you previously quit? □ Yes □ No **If yes**, when?________________________

13. List which of your current eating and lifestyle habits will be the top 3 most challenging to change or require the most work to maintain? 1. ________________________________
2. ______________________________3. ______________________________

14. List which of your current eating and lifestyle habits are going well and/or will be the easiest for you to maintain?________________________________________________

15. List any changes you have made in the past 3-6 months to be healthier.

16. List something you are planning to start working on this month for better health:____________

______________________________________________________________

**24 Hour Food Log**: In detail, describe a typical 24 hour day of eating. Note what you eat and drink throughout the day including typical portions and how the foods are prepared.

| **Time** | **Describe Food or Beverage Item; include Amount eaten** (e.g., ½ cup, 8 oz, etc.), **method of preparation** (e.g., Baked, pan fried, deep fried, steamed, grilled, boiled, microwaved, etc.) | **Calories (if known)** |
|---|---|---|
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