Nutrition Questionnaire

Name: _____ Preferred Name: _____

Date of Birth: _____ Age:_____ Sex: ☐ Male ☐ Female

For Women: Do you have plans for 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+ years 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 loss medications such as: Meridia, 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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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 or 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 the 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 relationships to you: _____

_____

Who does your grocery shopping: ☐ Self If not self, please list: _____

Who does the cooking: ☐ Self If not self, 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: _____

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 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 ☐ 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. How many times do you eat breakfast in a week?

☐ Rarely ☐ 2-3 times/week ☐ 4-6 times/week ☐ Daily

5. Do you often snack, nibble or graze throughout the day? ☐ **Yes** ☐ **No**

If yes, describe snack. _____

6. How long do your meals typically last?

☐ 5 minutes or less ☐ 5-15 minutes ☐ 20 – 30 minutes ☐ 30 minutes or more

7. 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

8. Where do you typically eat? ☐ Table ☐ In front of TV ☐ Office ☐ Car/On the go ☐ Other _____

9. With whom do you typically eat? ☐ Alone ☐ With spouse/partner/family/friends/coworkers

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

☐ _____/day ☐ _____/week ☐ _____/month

Where (list typical choice)?_____

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

☐ _____/day ☐ _____/week ☐ _____/month

Please list examples: _____

12. 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: _____

_____

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

☐ _____/day ☐ _____/week ☐ _____/month

List any specific sweets you eat: _____

14. Do you keep a food log or journal tracking daily intake? _____

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

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)**