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.

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<tr>
<th>Name of Medication</th>
<th>Year used</th>
<th>Length of time</th>
<th>Pounds lost</th>
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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.

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<th>Name of diet</th>
<th>Year</th>
<th>Length of time</th>
<th>Pounds lost</th>
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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 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: __________________________________________________________________________________________

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.

<table>
<thead>
<tr>
<th>Time</th>
<th>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.)</th>
<th>Calories (if known)</th>
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