



**Bariatric Nutrition Questionnaire**

Please complete this form and bring it to your first nutrition meeting

Name: \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Desired Goal Weight \_\_\_\_\_

Why are you seeking weight loss surgery at this time? \_\_\_\_\_

Why do you think success is possible this time? \_\_\_\_\_

**Dieting & Weight History**

What was your highest adult weight and when? \_\_\_\_\_

What was your lowest adult weight and when? \_\_\_\_\_

What is your usual body weight range? \_\_\_\_\_

Indicate your childhood weight status:  Under  Average  Over

Reason/s for your weight gain \_\_\_\_\_

Which statement(s) best describes why you think you are overweight?

- I eat normal amounts of foods but have an abnormal metabolism
- I eat larger than normal amounts of healthy foods
- I eat larger than normal amounts of healthy foods as well as sweets and snacks
- I tend to eat a good amount of sweets and high calorie snacks
- I am a compulsive eater
- Other: \_\_\_\_\_

Historically, have you ever used any of the following to control your weight?

- Binge eating and purging
- Binge eating followed by restriction
- Vomiting
- Laxatives
- Diuretics

- Nonprescription medications or over-the-counter weight loss pills
- Prescription medications i.e. Phen-fen, meridia, orlistat...

Please indicate the following methods of weight loss you have attempted and comment on your experience with it. You may indicate pounds lost and length of time on program

**Commercial Diets**

**Comments**

- Weight Watchers
- Jenny Craig
- Overeaters Anon
- TOPS
- Nutrisystem
- Other

**Prescription Meds**

**Comments**

- Redux (dexfenfluramine)
- Pondimin (fenfluramine)
- Fen/Phen
- Phentermine/Fastin/Adipex
- Meridia
- Xenical/Alli
- Other

**Liquid Diets**

**Comments**

- Optifast
- HMR
- Slimfast
- Other

**Popular**

**Comments**

- Atkins
- Pritikin
- Southbeach
- Mac Dougal
- Self Initiated

Medical and Health Care  
Treatments

Comments

- Previous Gastric Surgery
- Jaw Wiring
- Other Surgery
- Acupuncture
- Hypnosis
- Other

***Nutrition History***

How many times a day do you eat? 1    2    3    4    5    6    7    8

Indicate which meals/snacks you typically eat:

- Breakfast    am snack    lunch    pm snack    dinner    evening snack

How many **meals per week** do you eat the following...

- Fast foods \_\_\_\_\_
- Takeaways \_\_\_\_\_
- Cafeteria \_\_\_\_\_
- Sit down restaurants \_\_\_\_\_
- Frozen meals \_\_\_\_\_

Who prepares your meals? \_\_\_\_\_

Who does the shopping? \_\_\_\_\_

Do you like to cook? \_\_\_\_\_

Do you feel as if you frequently need to "eat on-the-run?" \_\_\_\_\_

Which of the following beverages do you drink and how much?:

**Coffee:**  regular  decaf  latte    How much? \_\_\_\_\_ day \_\_\_\_\_ week

**Tea:**  regular  decaf  Chai    How much? \_\_\_\_\_ day \_\_\_\_\_ week

**Juice:**  natural             fruit drinks    How much? \_\_\_\_\_ day \_\_\_\_\_ week

**Soda:**  regular             diet            How much? \_\_\_\_\_ day \_\_\_\_\_ week

**Smoothies:** How much? \_\_\_\_\_ day \_\_\_\_\_ week

**Milk:**  whole  2%  1%  skim    How much? \_\_\_\_\_ day \_\_\_\_\_ week

**Water:**  tap  bottled still  carbonated    How much? \_\_\_\_\_ day

**Alcohol:**  wine  beer  mixed drinks    How much? \_\_\_\_\_ day \_\_\_\_\_ week

How often do you eat some sort of fried food such as French fries, fried chicken, fried fish, tempura, potato chips or tortilla chips? How many times? \_\_\_\_\_day \_\_\_\_\_week

Which of the following fats do you use regularly? butter  margarine salad dressing  
oil mayonnaise  cream cheese

How often do you eat red meat? \_\_\_\_\_

How often do you eat poultry? \_\_\_\_\_

How often do you eat fish? \_\_\_\_\_

How often do you eat sweets (cookies, cakes, candy, ice cream, chocolate)? \_\_\_\_\_  
\_\_\_\_\_

Do you feel you crave any of the following foods?:

Rice  Pasta  Bread Cereal Potatoes?  Other \_\_\_\_\_

How often do you eat fruit? \_\_\_\_\_

How often do you eat vegetables? \_\_\_\_\_

Do you drink milk or eat cheese or yogurt everyday?  Yes  No

How often do you chew gum? \_\_\_\_\_

What do you perceive as the biggest weakness in your diet? \_\_\_\_\_  
\_\_\_\_\_

What are your favorite foods? \_\_\_\_\_  
\_\_\_\_\_

What foods do you avoid and why? \_\_\_\_\_  
\_\_\_\_\_

Do you get up at night to eat? Yes  No      What do you eat when you get up? \_\_\_\_\_

Do you consume more than half of of your daily calories after 7 pm? Yes  No

Does it take you longer than 10 minutes to eat a meal? Yes  No

If you use eating as an emotional outlet what will you substitute when your eating is restricted? \_\_\_\_\_  
\_\_\_\_\_

***Exercise History***

How physically active are you?  Very Active    Active    Average    Inactive  
 Very Inactive    Other \_\_\_\_\_

What do you do for physical activity and how often do you do it?

Activity	Number of Times/Week	How Long
<input type="checkbox"/> Walking		
<input type="checkbox"/> Bicycling		
<input type="checkbox"/> Swimming		
<input type="checkbox"/> Water exercises		
<input type="checkbox"/> Golf - walking		
<input type="checkbox"/> Golf - cart		
<input type="checkbox"/> Tennis		
<input type="checkbox"/> Aerobics		
<input type="checkbox"/> Weight training		
<input type="checkbox"/> Other		

How long have you been engaged in your current regimen? \_\_\_\_\_

Is there anything that prevents you from being physically active? \_\_\_\_\_

How committed are you to incorporating daily physical activity into your lifestyle?  
 Rate from 1(not committed) to 10 (it will happen without a doubt) \_\_\_\_\_

***Support System***

What are the attitudes of the following people about your attempt(s) to lose weight?

	Negative	Indifferent	Positive
Spouse			
Children			
Parents			
Employer			
Friends			

Do these attitudes affect your weight loss or gain?    Yes    No

If yes, please describe: \_\_\_\_\_

Is there somebody to assist you with activities of daily living post operatively? \_\_\_\_\_

***Medical History***

Which of the following conditions do you have?     Sleep Apnea                       Diabetes

High Cholesterol                       Hypertension                       Arthritis                       Heart Disease

Polycystic Ovary Syndrome                       Gastric Reflux or Heartburn                       Depression

Other \_\_\_\_\_

Please list the medications you currently take: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please list vitamins, minerals, and herbal supplements that you currently take: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please list any food allergies and/or intolerances: \_\_\_\_\_

\_\_\_\_\_

Have you been treated by a mental health professional in the past? \_\_\_\_\_

Please indicate the condition: \_\_\_\_\_

***Women only***                      Do you currently menstruate?                       Yes                       No

If yes, what birth control method do you use? \_\_\_\_\_  None

***Miscellaneous***

Do you have any questions or concerns that you specifically want to address?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_