Bariatric Nutrition Assessment Form

Patient's Last Name_____First _____Middle _____

Birth Date_____ Age___ Gender ☐ Male ☐Female Marital Status: ☐Married ☐Single
Home phone:_____ Cell Phone:_____ Email Address:_____

Surgery Planned: ☐Roux-en-Y Gastric Bypass ☐Sleeve Gastrectomy ☐ Gastric Balloon

Live with: ☐Spouse ☐Family ☐Friend ☐Alone

Employment: ☐ Full time ☐Part time ☐Retired ☐Student ☐Other
Occupation: _____ Work hours: _____

Medical History

Do you have a history of (please circle)

☐Diabetes ☐High cholesterol ☐Cancer ☐Arthritis

☐High blood pressure ☐Heart Disease ☐Sleep Apnea

Have you ever been diagnosed with an eating disorder? ☐ Yes ☐No

If yes what type? ☐ Binge Eating ☐ Anorexia Nervosa ☐ Bulimia

☐ Other _____

Check all over-the-counter medications you take:

☐ Multi vitamins (brand):_____

☐ Single vitamins (vitamin C,E, etc) Types:_____

☐ Calcium (type)_____

☐ Herbs (type)_____

☐ Other_____

List all prescription medications you take

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you drink alcoholic beverages? ☐ Yes ☐No

If yes, what do you drink? ☐ Beer ☐ Wine ☐ Mixed drinks ☐ Liquor

Do you smoke? ☐ Yes ☐No If yes how much do you smoke in 24 hours?_____
How many hours do you usually sleep (out of a 24 hour day) _____

What time to you wake up?_____ What time is your first meal?_____

Wake during the night to eat? ☐Yes ☐ No

Do you have any food allergies / intolerances? _____

_____

Do you follow any religious or cultural rules that influence what or how you eat? ☐ Yes ☐No

If yes, please explain:_____

_____

How do you learn best? ☐Verbal (explanation) ☐ Demonstration ☐ Written

☐ Other_____

Have you seen a dietitian before: ☐ Yes ☐No

Weight loss programs attempted:

Program	Dates Attempted	Weight Loss	Weight Gained	Supervised Y/N
☐ Weight Watchers				
☐ Jenny Craig				
☐ Slimfast				
☐ Special K				
☐ Atkins				
☐ Nutrisystem				
☐ Hospital-based program				
☐ Exercise program				
☐ Diet pills				
☐ Other				

Height: _____ Current weight: _____ BMI: _____

Highest adult weight: _____ Date: _____

Lowest adult weight: _____ Date: _____

Recent weight change: ☐Yes ☐ No If yes: pounds lost _____ pounds gained _____

What is your goal weight? _____

How much weight do you expect to lose as a result of weight loss surgery?

☐ Less than 50 lbs. ☐ 50-100 lbs. ☐ 100-150 lbs. ☐ More than 150 lbs.

Onset of weight gain (circle one) Childhood Adolescence Adulthood

Looking back, what would you attribute to the weight gain at that time? _____

_____

Patterns/habits

Diet recall:

Wake up: _____

Breakfast: _____

Snack: _____

Lunch: _____

Snack: _____

Dinner: _____

Snack: _____

Feeling after meals: ☐ comfortable ☐ stuffed ☐can eat more

Sometimes I feel "out of control" when eating? ☐Yes ☐ No

Who shops for and prepares food at home? _____

_____

Nutrition Quality

Do you eat fruits daily: ☐Yes ☐ No

Do you eat vegetables daily: ☐Yes ☐ No

Do you eat processed foods daily: ☐Yes ☐ No

Do you often eat empty calorie foods daily (sweets, fatty/salty foods) ☐Yes ☐ No

Do you drink high calorie beverages? ☐Yes ☐ No

If yes, what kind: ☐Juice ☐Soda ☐Whole milk

How many per day:_____

How often do you eat out during the week? _____

Fast-food restaurants:_____

Take-out / delivery:_____

Restaurants:_____

Physical activity pattern:

Work related activity: ☐Sedentary ☐Moderate ☐Heavy

Time spent in sedentary activities per day (computer, TV, etc.) _____

Planned exercise: Type_____ Time spent _____

If none, list any physical conditions that limit activity? _____

_____

Please complete the following sentences:

1. The main reason I have been unable to lose weight or maintain lost weight is because_____

   _____

   _____

2. I want to lose weight or I have decided to have weight loss surgery because_____

   _____

   _____

3. Questions I would like to discuss with the dietitian are:_____

   _____

   _____