

Nutrition Questionnaire

Please bring the form with you on your initial clinic visit.

Date _____ Name _____

1. How long have you been considering weight loss surgery?

Weight History

2. What is your current weight? _____ LBS

3. What is your desired goal weight at 12-18 months after surgery? _____ LBS

4. How many pounds do you need to lose to achieve your weight goal? _____ LBS

5. When did your weight problem begin? _____ childhood _____ adolescent
_____ teenager _____ 10 years ago _____ 20 years ago _____ 30 years ago
_____ throughout life other _____

6. What do you think is reason for your weight gain?
_____ injury _____ pregnancy _____ overeating _____ poor eating habits _____ heredity
_____ lack of exercise _____ marriage _____ smoking cessation _____ stress
_____ divorce other _____

7. What has been your highest adult weight? _____ LBS

8. When you lost weight in the past, how many pounds did you lose on average with each attempt?

Weight loss _____ small (<15 lbs) _____ moderate (15-49 lbs) _____ large (>50lbs)

9. What has been you most successful diet? _____
Why _____

Exercise History

(for staff use only MIP _____ MEP _____ HGS _____)

10. Do you currently exercise? _____ yes _____ no

If yes, what do you do for exercise,

Exercise	Days/week	Time spent
_____	_____	_____
_____	_____	_____

If No,
Why _____

Diet Assessment

11. How many meals per day do you eat? _____ one meal _____ two meals _____ three meals
_____ one to two meals _____ two to three meals _____ three or more meals

If you skip meals what meal(s) do you usually skip:

___ breakfast ___ lunch ___ dinner

How many days a week do you skip this meal _____

12. I eat out for Breakfast ___ rarely ___ sometimes ___ often ___ daily

Lunch ___ rarely ___ sometimes ___ often ___ daily

Dinner ___ rarely ___ sometimes ___ often ___ daily

13. Are your meals?

___ large portion ___ extra large portions ___ high fat ___ high carbohydrate

___ high sugar

14. How often do you snack?

___ a.m. snack ___ p.m. snack ___ evening snack ___ snack between all meals

___ grazing on food throughout the day

15. What beverages do you drink (please mark how many ounces you drink of each daily)

___ water ___ whole milk

___ diet soda ___ 2% milk

___ regular soda ___ 1% milk

___ regular coffee ___ skim milk

___ decaf coffee ___ juice

___ regular tea ___ sweet tea

___ decaf tea ___ unsweetened tea

16. Do you drink alcohol? ___ yes ___ no If yes what type how much and how often. _____

17. Do you take a Multivitamin? ___ yes ___ no

18. Do you smoke? ___ yes ___ no if quit, when _____

From the list below what triggers you to eat:

___ availability of food ___ depression

___ loneliness ___ boredom

___ habit ___ hunger

___ lack of appetite awareness ___ self reward

___ external cues ___ comfort

___ stress ___ PMS

___ social situations ___ anxiety

___ sadness other _____

___ anger

How would you describe your eating habits?

- | | |
|---|--|
| <input type="checkbox"/> Skip one meal per day | <input type="checkbox"/> feeling disgusted or guilty after overeating |
| <input type="checkbox"/> Reported often eating (i.e. grazing) | <input type="checkbox"/> Eating large amounts of food throughout the day |
| <input type="checkbox"/> Rapid eating | <input type="checkbox"/> Middle of the night eating |
| <input type="checkbox"/> Eating until uncomfortably full | |
| <input type="checkbox"/> Eating alone out or embarrassment | |

Personal Data	
Today's Date:	
Full Name:	
Birth Date:	
Soc Security #:	
Address:	
City, State, ZIP:	
Work Phone:	
Home Phone:	
E-mail Address:	
Occupation:	
Marital Status:	

Insurance Information	
Insurance Company:	
Policy Holder's Name:	
SS# of Policy Holder:	
Policy Number:	
Address:	
City, State, ZIP:	
Person Contacted:	
Telephone:	
Fax Number:	

Family Physician Information	
Family Physician:	
Address:	
City, State, ZIP:	
Office Phone	
FAX number:	

Section II

Body Size and Weight Information- List Maximum for Each Year				
Weight 1992:			Weight 1997:	
Weight 1993:			Weight 1998:	
Weight 1994:			Weight 1999:	
Weight 1995:			Weight 2000:	
Weight 1996:			Weight 2001:	
Current Weight:				
Height:			Waist Measurement:	

Previous Attempts at Weight Loss					
Program:	Year:	Months:	Physician Supervised?	Lbs. Lost:	Weight Regained?

List any other Attempts:	
List Medications Used to Lose Weight and Results:	
Describe any Family History of Obesity:	

Section III

Do you have a Psychiatrist:	Yes _____ No _____
If Yes:	
Psychiatrists Name:	
Address:	
City, State, ZIP:	
Office Phone:	
Date Last Seen:	

Please List all Allergies:	
Please List all Medications Currently Taking and Dosages:	
List Prior operations (indicate if done with laparoscope):	
Describe in your words how your obesity is affecting your life:	

Section IV
Obesity and Selected Organ Function

Check all that apply

Cardiovascular

- Heart problems (*requiring medication*)
- Chest Pains
- Racing Heart/skipping
- High blood pressure (*requiring medication*)
- Chest tightness
- Shortness of breath (SOB)
- High Cholesterol (*requiring medication*)
- High Triglycerides (*requiring medication*)
- Feel tired all the time

Diabetes

- Diabetes – Type I or II (*requiring medication*)
- Pre-Diabetic (abnormal glucose tolerance test)
- Gestational Diabetes ___ Age of Diagnosis
- Hypoglycemia (low blood sugar)

Thyroid Problems

- Thyroid Problems (*requiring medication*)

Gastrointestinal

- Gallbladder Problems ___ Removed?
- Stomach Ulcers (*requiring medication*)
- Heartburn ___ Daily? ___ Nocturnal?
- Regurgitation? ___ Requiring Medication?
- Diarrhea or constipation

Respiratory

- Asthma Last attack?
- ? Bronchitis # of times in past 2 years ___ Is it recurring? Yes ___ No ___
- Pneumonia
- Blood clots in lungs
- Smoker Starting age ___ When did you stop?
- Smokeless Tobacco
- Sleep Apnea
- Snore
- Wake up gasping ___ with a smothered feeling?
- Using CPAP or BI-PAP

Check all that apply

Musculoskeletal			
	Mild	Moderate	Severe
Hip Pain			
Knee Pain			
Ankle Pain			
Feet Pain			
Back Pain			
Neck Pain			
Arthritis			

Check all that apply

Degenerative Joint Disease	
Using anti-inflammatory or pain medicine	
Swelling in the legs	
Swelling in the feet	
Swelling in the hands	
Varicose veins	
Ulcers of the legs	
Problems with leg veins	

For Females

- Problems Conceiving
- Are you regular?
- Any pain with period?
- Loss of urine

Nero- Psychiatric

- Depression because of obesity? requiring medication?
- Seizures requiring medication?
- Severe Headaches requiring medication?
- Visual Problems
- Been in counseling
- History of alcohol abuse. How long have you been dry
- History of drug abuse. How long have you been clean
- Eating disorder. Bulimia Anorexia-Nervosa

Family History (parents, grandparents, brothers, sisters)

	Parents	Grandparents	Brothers	Sisters	Other
Obesity					
Diabetes					
Heart Disease					
High Blood Pressure					
Cancer & Type					
Arthritis					
Early Death & Cause					

Sleep Apnea Self Test

(You do not need to complete if you know you have sleep apnea)

	YES	NO
Do you Snore?		
Have you been told that you hold your breath or stop breathing during sleep?		
Do you wake up Gasp for Breath? Do you awaken with headaches		
Do you fall asleep frequently while reading?		
Have you fallen asleep while driving or stopped at a light?		
Do you have jerking movements while sleeping?		
Do you still feel exhausted after 8 hours of sleep?		

Total # of YES answers: _____

If you answered **YES to more than four of the above questions**, you may have sleep apnea and you should talk to your doctor about a sleep study.

Impact of weight on Physical Functions

Please check the answer in the right column according to how well it describes you in the past week:

Physical Function	Always true	Usually true	Sometimes true	Rarely True	Never true
Because of my weight I have trouble picking up objects					
Because of my weight I have trouble tying my shoes					
Because of my weight I have trouble using stairs					
Because of my weight I have trouble putting on or taking off my clothes					
Because of my weight I have trouble with morbidity					
Because of my weight I have trouble crossing my legs					
I feel short of breath only with mild exertion					
I am troubled by painful or stiff joints					
My ankles and lower legs are swollen at the end of the day					
I am worried about my health					
Self Esteem					
Because of my weight I am self conscious					
Because of my weight my self esteem is not what it could be					
Because of my weight I feel unsure of myself					
Because of my weight I don't like myself					
Because of my weight I am afraid of being rejected					
Because of my weight I avoid looking in mirrors or seeing myself in photos.					
Sexual Life					
Because of my weight I do not enjoy sexual activity					
Because of my weight I have little or no sexual desire					
Because of my weight I have difficulty with sexual performance					

Because of my weight I avoid sexual encounters whenever possible					
Public Distress					
Because of my weight I experience ridicule, teasing, or unwanted attention					
Because of my weight I worry about fitting into seats in public places					
Because of my weight I worry about fitting through aisles or turnstiles					
Because of my weight I worry about finding chairs that are strong enough to hold my weight					
Because of my weight I experience discrimination by others					
Work: (if you are a homemaker or retired, answer this questions with respect to your daily activities)					
Because of my weight I have trouble getting things accomplished or meeting my responsibilities					
Because of my weight I am less productive than I should be					
Because of my weight I don't receive appropriate raises, promotions, or recognition at work					
Because of my weight I am afraid to go to job interviews					