lifestyle medicine center
MIDLAND HEALTH

Bariatric Nutrition Questionnaire

To give you personalized care and attention, the dietitian needs to know a little bit about you and your lifestyle. Please take a few minutes to answer the following questions.

Name:		**Date of Birth:**
Age:	**Height:**	**Weight:**

General Information

In your own words, please describe what you hope to accomplish by losing weight?

____
____
____

Do you have any drug allergies? Yes☐ No☐

If yes, please list:

____
____
____

Do you currently take any medications? Yes☐ No☐

If yes, please list:

____
____
____

Do you currently take any vitamins or supplements? Yes☐ No☐

If yes, please list:

____
____
____

Do you use tobacco products? Yes☐ No☐ If yes, how much? _______________________________

Do you drink alcohol? Yes☐ No☐ If yes how often do you drink alcohol?

☐0-1 times/month ☐ 2-3 times/month ☐ 1-2 times/week ☐3-4 times/week ☐ 5+ times/week

Do you use illicit drugs? Yes☐ No☐ If yes, which one? _______________________________

What is your health history? (Check all that apply:)

☐Heart disease ☐ High blood pressure

☐ Diabetes ☐ High cholesterol

☐ Cancer ☐ Other___________________

Weight History

What procedure are you interested in? ☐ Gastric Sleeve ☐ Gastric Bypass ☐ Undecided

What is your goal weight?___________________

What is the highest you have ever weighed?____

Have you ever used weight loss medications ☐ Yes ☐ No If yes, what medications have you used____

____

Have you ever had gastric surgery☐ Yes ☐ No If yes, which one?

____

Diet History

How would you rate current eating habits? Excellent ☐ Good ☐ Fair ☐ Poor ☐

Which commercial or fat diets have you tried in the past? Check all that apply

☐ Atkins	☐ Low fat	☐ Low Carb
☐ CHIP	☐ South Beach	☐ Paleo
☐ Mediterranean Diet	☐ Elimination Diet (Allergy)	☐ Vegan
☐ Jenny Craig	☐ Weight Watchers	☐ Vegetarian
☐ D.A.S.H	☐ Gluten Free	☐ Slim Fast/Meal Replacements

Other:_________________

Eating Patterns

How many meals do you usually eat per day? ☐ 0-1 ☐ 2-3 ☐ 4+

How many snacks do you usually eat per day? ☐ 0-1 ☐ 2-3 ☐ 4+

How often do you skip meals? ☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐Always

Do you have any food intolerances or sensitivities? ☐ Yes ☐ No If yes___________________________

How often do you eat out per week (fast food or restaurants) ☐ 0-1 ☐ 2-4 ☐ 5 or more

Who does the grocery shopping? ☐ Self ☐ Spouse ☐ Parent ☐ Other________

Who does the meal preparation and cooking? ☐ Self ☐ Spouse ☐ Parent ☐ Other________

Would you consider yourself an emotional eater? ☐Yes ☐No

If yes, what triggers you? ☐ Sadness ☐Anxiety ☐Stress ☐Boredom ☐Anger

Please fill out the chart below with all the food and beverages you ate in the past 24 hours. Enter the description and amount of each item as precisely as you can.

Meal	Time	Food/Beverages Consumed
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		
Other Beverages		

Which of the following factors apply to you eating habits and current lifestyle? Check all that apply

- ☐ Likes healthy food
- ☐ Dislikes healthy food
- ☐ Reads nutrition labels
- ☐ Fast eater
- ☐ Eat slowly
- ☐ Prepare meals at home
- ☐ Rely on packaged/fast food
- ☐ Likes cooking
- ☐ Dislikes cooking
- ☐ Do not know how to cook
- ☐ Knows how to cook
- ☐ No time to prepare meals/snacks
- ☐ Plans Meals
- ☐ Do not plan meals
- ☐ Eats a variety of foods
- ☐ Late night eater
- ☐ Eats most meals at table
- ☐ Eats while watching TV/Computer
- ☐ Lives alone/eats alone

Physical Activity

Do you currently exercise? Yes ☐ No ☐

What type of exercise?________ How many times?________days/week How long? _______minutes/day

Do you have any exercise limitations? Yes ☐No ☐ If yes, please describe____

How much time do you spend on the screen (computer/TV/Phone)?______________________________hrs