Rex Bariatric Specialist

Name:
DOB:

NUTRITIONAL AND DIET QUESTIONAIRE

A. Weight/Dieting History:

1. When did you begin to struggle with weight gain?
   a. Life-long struggle since childhood
   b. At age _________

2. Please list your heaviest adult weight (exclude pregnancies): __________ lbs __________ age.

3. Please list your lowest adult weight: __________ lbs __________ age.

4. Have you tried weight loss through structured dieting or other treatment? ☐ Yes ☐ No

5. If yes, list all food/ liquid diets or treatments attempted. Many insurance carriers require this information; therefore, please provide an accurate and complete listing.

Common Diets/Programs:
Atkins/Low Carb
Grapefruit
Jenny Craig
Liquid Protein
Metabolife
Nutri-System
Optifast/Medifast
Physicians Weight Loss Center
Slim Fast
South Beach Diet
TOPS
Weight Watchers
Volumetrics
Zone Diet

Behavioral Treatments:
Diet Counseling/Worked with Dietitian
Exercise Trainer
Hypnosis
Personal Physician
Residential Diet Center

Name of Diet/Treatment	Lbs. Lost	Physician directed?

6. List all medications used by you for weight loss. Listed below are the most common medications. Please provide an accurate and complete list of any medications used in the past: Acutrim, Alli, Bontril, Didrex, Phentermine, Xenical, Dexatrim, Fen/Phen, Meridia, Redux.

7.

Medication & Dose	Start year	Length (Mos.)	Lbs. Lost	Physician directed

NUTRITIONAL PRE-SCREENING ASSESSMENT

8. Have you had weight loss surgery in the past?

    a. Physician:______________________________________
    b. Date:____
    c. Type of Surgery: _______________________________
    d. Weight When You Began Program:________________
    e. Total Pounds Lost:______________________________

9. Do you have diabetes?
    a. No
    b. Yes
        i. Type 1 Diabetes
        ii. Type 2 Diabetes (known as adult onset)

    Are you testing daily blood sugars daily? ___________
    If yes, what is your recent blood sugar range? ______________
    Do you use insulin? _________
        Type________ Units________
        Type________ Units________

10. Are you on dialysis? ____
    *Renal dietitian contact info:*______________________________

11. Current use of nicotine?
    (ie. Cigarettes/e-cigarettes/cigars/pipes/chewing tobacco/nicotine gums or patches)
    a. Type? ____
    b. Frequency/Amount _______________________________

NUTRITIONAL PRE-SCREENING ASSESSMENT

Diet Behaviors (circle all that apply)

1. Current challenges to improving my health include:
   a. Lack of time
   b. Lack of motivation
   c. Work Schedule
   d. Too expensive
   e. Social Calendar
   f. Family responsibility
   g. Illness or physical limitation
   h. Traveling for work, etc
   i. Other__________________

2. My hidden sources of extra calories most likely come from:
   a. Large portions
   b. Soda/other beverages
   c. Sweets
   d. Chips
   e. Fried foods
   f. Eating while cooking
   g. Going out to eat
   h. Eating with distractions (TV/driving/etc)
   i. Eating when upset/stressed
   j. Eating when bored
   k. Other:_________________

3. How do you feel about making behavioral changes?
   a. Ready to start making changes now
   b. Ready to think about making changes
   c. Not ready to make any changes to my current lifestyle

4. How many meals do you eat out per week?

a. Breakfast: ______	Fast food	Café	Cafeteria	Restaurant
b. Lunch: _________	Fast food	Café	Cafeteria	Restaurant
c. Dinner: ________	Fast food	Café	Cafeteria	Restaurant

5. Do you skip any meals?
   a. Breakfast How many days per week?______
   b. Lunch How many days per week?______
   c. Dinner How many days per week?______

6. How often do you eat between meals?
   a. Seldom
   b. 1 time per day
   c. 2 time per day
   d. Graze throughout the day

7. What best describes your evening meal?
   a. Seldom eat dinner
   b. Lightest meal of the day
   c. Moderate size meal
   d. Largest meal of the day

8. Which sources of protein do you eat most often?
   a. Red meat (beef and pork)
   b. Fish and Chicken
   c. Eggs and Dairy
   d. Tofu, beans, and lentils

9. How often do you feel you are having appropriate portion sizes?
   a. I don't know
   b. Rarely
   c. Sometimes
   d. Often

NUTRITIONAL PRE-SCREENING ASSESSMENT

10. How many servings of fruit do you consume each day: ____________________

11. How many servings of vegetables do you consume each day: ______________
    a. With cheese, butter, or dressing
    b. Canned
    c. Fresh or frozen

12. Which types of carbohydrates do you choose most often:
    a. I avoid carbs
    b. Whole grains (brown rice/bulgar/barley/quinoa)
    c. Starchy vegetables (potatoes/peas/corn/beans)
    d. White/refined carbs (white rice/white pasta/white bread)
    e. Sweets (candies/cakes/muffins/etc)

13. How often do you eat low-fat dairy products?
    a. Seldom
    b. 1-2 times per week
    c. 1 time per day
    d. 2 times per day

14. Which types of drinks do you choose most often?
    a. Water
    b. Flavored water
    c. Fruit juice
    d. Coffee
    e. Sweet Tea
    f. Unsweet Tea
    g. Regular Soda
    h. Diet Soda

15. How many ounces of water do you drink on average each day? _________ ounces

16. How much alcohol do you consume?
    a. None
    b. 1-2 times per month
    c. 1-2 times per week
    d. 1 beverage per day
    e. 2-3 beverages per day
    f. More than 4 beverages per day

17. How often do you exercise for 20 minutes or more each week?
    a. Seldom
    b. 1-2 times per week
    c. 3-4 times per week
    d. Daily

    Do you have any limitations/current barriers to increasing exercise?____________________
    What exercise has your physician asked you to do? ________________________________

18. How many hours of sleep do you typically get a night?
    a. 1-2 hours
    b. 3-4 hours
    c. 5-6 hours
    d. 7 or more hours.

19. What changes have you made since starting the bariatric program?
    a. Reduced refined carbohydrates ("white foods")
    b. Increased physical activity
    c. Increased water consumption
    d. __________________________