COMMUNITY HEALTH And LIFE CENTER

Weight Loss Surgery
Nutrition Screening Evaluation Form

Name: _____ Age: _____ Birth Date: _____

Bariatric Surgeon: _____

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

Cell Phone: _____ E-mail Address: _____

Gender: ☐ Male ☐ Female

Live with: ☐ Spouse ☐ Family ☐ Friend ☐ Alone

Employment: ☐ Full-time ☐ Part-time ☐ Retired ☐ Student ☐ Other_____
Occupation: _____ Work Hours: _____

Have you seen a dietitian before? ☐ Yes ☐ No
If yes, for what diet? _____ When? _____ Where? _____

Have you had any previous weight loss surgeries? ☐ Yes ☐ No
If yes, what type(s)?_____When?_____

Height: _____ Present Weight: _____ BMI (if known):_____

Highest adult weight: _____ Date: _____

Lowest adult weight: _____ Date: _____

Recent weight change? ☐ Yes ☐ No How many pounds lost? ____ Gained? ____

What would you like to weigh? _____

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.

What age did you begin to gain excess weight? _____

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

Dietitian to complete: % estimated weight loss/surgery type_____

Weight loss expected: _____ Goal weight range: _____

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Check any of the following problems you had previously or are now experiencing:

- ☐ Hearing Problems
- ☐ Memory/Concentration
- ☐ Blurred Vision
- ☐ Problems Reading
- ☐ Reflux/ Heartburn
- ☐ Hiatal Hernia
- ☐ Polycystic Ovary Syndrome
- ☐ Constipation/ ☐Diarrhea
- ☐ Nausea/ ☐Vomiting
- ☐ Colon Surgery
- ☐ Heart disease
- ☐ High Blood Pressure
- ☐ Congestive Heart Failure
- ☐ Stroke
- ☐ High Cholesterol
- ☐ Anemia
- ☐ Anxiety/Depression
- ☐ Mental Health Problems
- ☐ Liver Disease
- ☐ Back, Knee, Hip Problems
- ☐ Asthma
- ☐ Kidney Disease
- ☐ Pre-Diabetes
- ☐ Diabetes: Type 1___ Type 2 ___
- ☐ Thyroid disease
- ☐ Excessive Thirst
- ☐ Frequent Urination
- ☐ Sleep Apnea
- ☐ Cancer
- ☐ Loss of Feeling/☐Tingling/☐ Pain in: __Feet __Legs __Hands __Arms

Please list any other medical problems or surgeries (not listed above). Also, include any medical procedures (such as balloon angioplasty): _____

For women: Are you currently pregnant? ☐ Yes ☐ No
Are you planning to become pregnant? ☐ Yes ☐ No
Are you currently breastfeeding? ☐ Yes ☐ No
Age at menopause: _____

Check all over-the-counter medications you take:

- ☐ Multi-vitamins: brand:_____
- ☐ Single vitamins (Vitamin C, E, etc.): type(s):_____
- ☐ Calcium: type: _____amount:_____
- ☐ Herbs: type(s):_____
- ☐ Other over-the-counter medications:_____

Write down all the prescription medications you take.

1._____ 5._____

2._____ 6._____

3. _____ 7._____

4._____ 8. _____

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On a scale of 1 -5, circle the number that best describes you or your situation.

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
I have family and friends that will be a strong support system for me after surgery.	1	2	3	4	5
I have researched bariatric surgery and talked with people who have had weight loss surgery.	1	2	3	4	5
I will be involved with my follow-up care and attendance at bariatric support groups after surgery.	1	2	3	4	5
I am highly motivated.	1	2	3	4	5
I am quick to learn and can easily follow directions.	1	2	3	4	5

1. Have you ever been diagnosed with an eating disorder? ☐ Yes ☐ No
   If yes, what type? ☐ Binge Eating ☐ Anorexia Nervosa ☐ Bulimia
   ☐ Other: _____
2. Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how often? _____
   If yes, what do you drink? ☐Beer (regular) ☐Beer (light) ☐Wine ☐Mixed drinks
   ☐Brandy ☐Liquor (Gin, Rum, Vodka) ☐Liqueur (Kahlua, Bailey's, Crème de Menthe)
3. Do you use marijuana, cocaine, crack or other recreational drugs? ☐ Yes ☐ No
4. Do you smoke? ☐ Yes ☐ No
   If yes, how much do you smoke in 24 hours? _____
   If no, have you ever smoked? ☐ Yes ☐ No If yes, when did you quit? _____
5. How many hours do you usually sleep (out of a 24 hour day)? _____
   What time do you get up? _____ What time is your first meal? _____
6. Do you have any food or medication allergies? ☐ Yes ☐ No
   If yes, please list: _____
7. Do you follow any religious or cultural rules that influence what or how you eat?
   ☐ Yes ☐ No If yes, please explain: _____
8. How do you learn best? ☐ Verbal (explanation/tapes/video) ☐ Demonstration
   ☐ Written (books/pamphlets/guidelines) ☐ Other (please explain):_____

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Please check (✓) everything below that describes your diet and/or lifestyle behaviors:

	1. I eat large portions, get seconds, or overfill my plate.		11. I eat too quickly, chew foods poorly or take too large of bites.
	2. I skip meals or go for longer than five hours between meals.		12. I am an emotional eater or I eat more when I am stressed.
	3. I dine out (includes carry-in) more than three times a week.		13. I drink less than 64 ounces (8 cups) daily (all fluids count).
	4. I frequently eat fried foods, fast foods, and high fat foods.		14. I gulp (rather than sip) my beverages or drink too quickly.
	5. I frequently eat sweets and desserts (candy, cakes, cookies, pies).		15. I drink beverages with calories (juice, punch, soda, sweet tea, etc.).
	6. I graze (snack on food all day long) while doing other things (reading, computer work, watching TV).		16. I usually drink more than two carbonated drinks (soda pop, bubbly drinks) daily.
	7. I eat high calorie snacks.		17. I usually drink more than two cups of coffee or caffeine drinks daily.
	8. I wake up and eat during the middle of the night.		18. I usually drink two or more alcoholic beverages daily.
	9. I don't eat enough protein (less than 4-6 ounces of meat, fish or poultry daily).		19. I lack sufficient exercise (less than 30 minutes on most days of the week).
	10. I get less than three dairy servings (milk, yogurt, cheese) daily.		20. Other:

Dietitian to fill out: Pre-surgery goals selected: _____

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Please check (✓) those statements below that apply to you. Identifying problem areas before surgery is the first step towards being successful after surgery.

	I have a relative or friend who may try to hinder my weight loss efforts.		In the past I have not been good about taking vitamins and/or medications.
	I rely on someone else to purchase and/or prepare my food.		English is not my first language. I have a language barrier.
	I have problems with chewing and swallowing.		My calorie intake is already low (below 1000 calories per day).
	I have a physical condition(s) that limits activity or exercise.		I am a stress eater or emotional eater.
	I have an eating disorder.		I have problems with eyesight or hearing.
	I have a difficult work schedule.		I never feel full even when I have eaten a lot.
	I may not be able to afford supplements.		I am addicted to food.
	I have difficulty making changes.		I would have a difficult time reducing or giving up: _____.
	Other:		Other:

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:

_____

_____

_____

Sample Menu (Use as an example to fill out the menu below):

Time	Meal	Foods and Beverages Include Amounts and How Food is Prepared
8:00 a.m.	Breakfast	1 cup coffee with 3 teaspoons sugar and one creamer
9:30 a.m.	Snack	Large toasted bagel with 2 tablespoons cream cheese 20 ounce soda pop
11:30 a.m.	Lunch	Wendy's Chicken BLT Salad with 2 packets of honey mustard dressing and croutons 20 ounce lemonade + refill
2:00 p.m.	Snack	Pretzels, grab-it size 16 ounce bottle cranberry juice
7:30 p.m.	Dinner	2 fried chicken breasts, extra crispy ½ c. green beans with ham 1 cup mashed potatoes with ¼ cup gravy 2 biscuits with 2 tablespoons butter 2 tablespoons honey 2 cans of beer
11:00 p.m.	Snack	6 Oreo Cookies 12 ounces 2% milk

Describe your usual daily eating pattern:

Time	Meal	Foods and Beverages Include Amounts and How Food is Prepared
	Breakfast	
	Snack	
	Lunch	
	Snack	
	Dinner	
	Snack	

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Name:_____ Height: _____ Weight: _____ Date: _____

Insurance companies often require a list of diets followed within the past 5 years. The best you can remember, please complete the form below. Refer to the last page for a list of popular diets.

	Name or Type of Diet	Year You Began This Diet	Number of Months on This Diet	Pounds Lost	Who Supervised This Diet? (Name of Doctor/Facility)
	EXAMPLE: Weight Watcher's	2012	5-6 months	30	
	EXAMPLE: Diet Pills	2018	2 months	5-10	Dr. Judy Medical Center TX
1.					
2.					
3.					
4.					
5.					
6.					

Use the information below to help you remember diets followed in the past 5 years so you can more easily complete the "History of Weight Loss Method's" form on the previous page.

Commercial Programs	Popular Diets or Fad Diets
Diet Center	Blood Type Diet
Diet Workshop	Body for Life
Jenny Craig	Cabbage Soup Diet
LA Weight Loss	Calorie Counting
NutriSystems	Carbohydrates Addicts Diet
Overeaters Anonymous (OA)	Dr. Phil's Ultimate Weight Loss
Physician's Weight Loss Center	Eat More, Weigh Less (Dr. Ornish)
Take Off Pounds Sensibly (TOPS)	eDiets.com
Weight Watchers	Glycemic Index
	Grapefruit
Prescription Diet Medications	Hollywood
Amphetamines	Low Carb (i.e. Atkins)
Meridia (sibutramine)	Low Fat
Phentermine (Fastin/Adipex/Ionamin)	Mayo Clinic Diet
	Protein Power
Xenical (orlistat)	Richard Simmons
	South Beach
Liquid Diets	Sugar Buster's
Carefast	The Zone
Formula 3	Volumetrics
HMR	
Medifast	**Therapy and Other Programs/Diets**
New Direction	
Optifast	Acupuncture
Slimfast	Behavior Therapy
	Diabetic Diet
Herbal and Non-Prescription Remedies	Exercise Programs
	Fasting
Alli	Hypnosis
Dexatrim	Inpatient psychiatric program
Ephedra (ma huang)	Previous weight loss surgery
Hydroxcut	Previous gastric stapling
Laxatives	Psychotherapy
Metabolife	Registered Dietitian