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?

□Skip one meal per day	□feeling disgusted or guilty after overeating
□Reported often eating (i.e. grazing)	□Eating large amounts of food throughout the day
□Rapid eating	□Middle of the night eating
□Eating until uncomfortably full	
□Eating alone out or embarrassment	