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)	
Rapid eating	Eating large amounts of food throughout the day
Eating until uncomfortably full	
Eating alone out or embarrassment	Middle of the night eating

Physician Questionnaire

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 1999:			Weight 2004:	
Weight 2000:			Weight 2005:	
Weight 2001:			Weight 2006:	
Weight 2002:			Weight 2007:	
Weight 2003:			Weight 2008:	
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	__Pain __ Inflamed __ Red

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 Gasping 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					

Written Agreement to Comply with Therapy

I have reviewed all the information provided to be by Dr. Ramy Awad regarding my obesity, the Roux-en-Y Gastric Bypass/Lap-Band, the strict postoperative dietary program, lifestyle modifications including and not limited to increased exercise. I also understand that follow-up clinic visit is an important aspect of care to avoid potential complications; and for optimal weight loss.

I have been given an opportunity to ask questions about management of my obesity, alternative forms of treatment, risk of non-treatment, the procedures to be used, and the risks and hazards involved. I believe that I have sufficient information concerning the Roux-en-Y Gastric Bypass/Lap-Band surgery.

I agree to comply, to the best of my ability with all therapy and recommendations made by my physicians and healthcare providers including:

☐ I will take vitamins and supplements as directed for the rest of my life.

☐ I will follow the guidelines of the postoperative diet.

☐ I will exercise on a regular basis after surgery.

☐ I will come in for follow-up appointments at 4 weeks, 3months, 6 months, and 12 months and at least every year after.

☐ I will not get pregnant for at least 1 year after my surgery.

_____ _____

(Signature of Patient) (Date)

Please sign legibly

_____ _____

(Signature of Provider) (Date)