INITIAL NUTRITION CONSULTATION QUESTIONNAIRE

Please fill out the attached sheets & bring this completed form to your Nutrition Consultation

THANK YOU

Laura Giannone, MS, RD, CDN
Emily Bostrom RD, CDN
Nutritionists for the Bariatric Program
Lutheran Medical Center
718-667-8100 Staten Island
718-630-8600 Brooklyn

Bariatric Surgical Program
Lutheran Medical Center
Nutrition Assessment

□ Staten Island □ Brooklyn

Name (please print) _____ Date_____
Gender □ Male □ Female

Telephone number (s)_____

Address_____

Email address_____

Date of birth _____ Age _____ Height _____

Current weight____ How long have you been overweight? _____

Lowest adult weight _____ When (year) _____

Highest weight _____ When (year) _____

What is your goal weight? _____

What type of procedure are you considering?
□ Lap-Band □ Gastric Bypass (Roux-en-Y) □ Sleeve gastrectomy

Briefly describe why you have chosen to have this procedure: _____
_____

Do you know anyone that had Bariatric surgery? □ Yes □ No
How do you know them? _____

How were you referred to this office?_____

To be completed by Nutritionist ONLY

DBW_____ % DBW_____ BMI_____

Initial MD visit_____ Insurance_____ Ht in cm_____

MEDICAL HISTORY

Are there any personal struggles in your life (physical or emotional), that are associated with physical limitations you experience due to your weight status? If so, briefly describe:

_____

_____

How frequent are these symptoms?

- □ Daily
- □ Weekly
- □ Monthly

How severe are they?

- □ Interfere with daily living
- □ Difficult to tolerate
- □ Somewhat bothersome

Do you have a history of any eating disorder, such as anorexia, bulimia or binge eating? If so, when and did you seek help?

_____

Do you have any of the following medical conditions? please circle:

High blood pressure	High blood cholesterol	Diabetes
Asthma	Sleep Apnea	Emphysema
Arthritis	Heart disease	Heartburn

Other: _____

What medications do you take, for the above conditions or anything else (list both prescriptions and over the counter):

_____

Do you have any allergy to medications? □ YES □ NO
If so, please list: _____

Do you have any family history of any of the above-mentioned medical conditions? If so, which conditions?

_____

Do you have a family history of obesity? □ YES □ NO

Have you ever had surgery? □ YES □ NO
If so, please list type and year: _____

FOR WOMEN: Do you have any menstrual irregularities, fibroids or ovarian cysts? _____

DIET INFORMATION

Please list any vitamins, minerals or herbal supplements you are currently taking:_____

Please list the Diets/Programs followed in the past:

Diet/Product	Year followed	Length of time followed	Amount of loss

How many times per week you eat out, get take-out and/or eat "fast food"? Please list some examples of places and types of foods you choose:

_____

Do you drink water each day? □ YES □ NO
If yes, how much / If not, why? _____

List other beverages you drink during the day:_____

_____

Do you drink alcoholic beverages? Circle the appropriate answer (s)

Daily Weekends Occasionally Seldom Never

How often do you eat the following foods:

	Daily	Weekly	Seldom	Never
Sweets (such as, ice cream, candy,etc.)	□	□	□	□
Fried and/or high fat foods (such as chips, KFC,etc.)	□	□	□	□
Butter, margarine, oil, mayo	□	□	□	□
Fresh fruits/vegetables	□	□	□	□
Dairy products (such as, milk, cheese, yogurt)	□	□	□	□

What good nutrition practices do you follow? (i.e. drinking water, drinking low fat milk vs whole…)?

_____

_____

What is your worst nutrition habit?

_____

_____

OTHER INFORMATION

Do emotional issues trigger eating? □ NO □ YES
If so, please describe _____

_____

Have you ever, or do you now, exercise? _____

What type of activity/activities? _____

_____

Briefly explain the reasons why you are considering Bariatric surgery:

THANK YOU!

Rev: 7/12 LG
EB