

Nutrition History and Questionnaire

Florida Surgical Weight Loss Center

Last Name: _____ First Name: _____

Address: _____

e-mail address: _____

DOB: _____ Occupation: _____

Highest Education Level Completed:

- Grade School High School College Graduate Degree

Surgery Type:

- AP Laparoscopic Band Placement Gastric Sleeve

Surgeon: _____

Anticipated date of surgery (if known): _____

Medical History (please check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Orthopedic surgery |
| <input type="checkbox"/> Cancer
Type: _____ | <input type="checkbox"/> High Triglyceride
Level | <input type="checkbox"/> Shortness of Breath
upon Exertion |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Type 1 Diabetes |
| <input type="checkbox"/> Gastric Reflux | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Type 2 Diabetes |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lupus | <input type="checkbox"/> Other |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Multiple Sclerosis | |

Please list any food allergies or intolerances: _____

Why do you want to lose weight?

What are some of the things that have kept you from accomplishing weight loss?

Who would you consider your "support persons" during this process?

Height: _____

Weight: _____

What is your goal weight? _____

What is the most you have weighed (in your adult life) and at what age? _____

What is the lowest you have weighed (in your adult life) and at what age? _____

Past Attempts at Weight Loss (please be as specific as possible):

Weight Watchers

Duration: _____

Amount of Weight Lost: _____ lbs

Reason for Stopping Program:

Jenny Craig

Duration: _____

Amount of Weight Lost: _____ lbs

Reason for Stopping Program:

Nutrisystem

Duration: _____

Amount of Weight Lost: _____ lbs

Reason for Stopping Program:

Optifast

Duration: _____

Amount of Weight Lost: _____ lbs

Reason for Stopping Program:

SlimFast

Duration: _____

Amount of Weight Lost: _____ lbs

Reason for Stopping Program:

Atkins

Duration: _____

Amount of Weight Lost: _____ lbs

Reason for Stopping Program:

Zone Diet

Duration: _____

Amount of Weight Lost: _____ lbs

Reason for Stopping Program:

HCG Diet

Duration: _____

Amount of Weight Lost: _____ lbs

Reason for Stopping Program:

South Beach Diet

Duration: _____

Amount of Weight Lost: _____ lbs

Reason for Stopping Program:

Overeaters Anonymous

Duration: _____

Amount of Weight Lost: _____ lbs

Reason for Stopping Program:

Paleo Diet

Duration: _____

Amount of Weight Lost: _____ lbs

Reason for Stopping Program:

Hypnosis

Duration: _____

Amount of Weight Lost: _____ lbs

Reason for Stopping Program:

MediWeight Loss
Duration: _____
Amount of Weight Lost: _____ lbs
Reason for Stopping Program:

Physician-supervised Diet
Duration: _____
Amount of Weight Lost: _____ lbs
Reason for Stopping Program:

Dietitian-prescribed Diet
Duration: _____
Amount of Weight Lost: _____ lbs
Reason for Stopping Program:

Cleanse/Detox Diet
Duration: _____
Amount of Weight Lost: _____ lbs
Reason for Stopping Program:

Any other "fad" diet
Elaborate: _____
Duration: _____
Amount of Weight Lost: _____ lbs
Reason for Stopping Program:

Self Diet
Elaborate: _____
Duration: _____
Amount of Weight Lost: _____ lbs
Reason for Stopping Program

Have you ever taken prescription or over-the-counter medications for weight loss, suppression of appetite or other dieting reason? If yes, please indicate below:

Type: _____
Duration: _____
Amount of Weight Lost: _____ lbs
Reason for Stopping _____

Type: _____
Duration: _____
Amount of Weight Lost: _____ lbs
Reason for Stopping _____

Have you ever attended a weight-loss retreat, rehab, or spa? If so, please indicate below:

Type: _____
Duration: _____
Amount of Weight Lost: _____ lbs
Reason for Stopping _____

Type: _____
Duration: _____
Amount of Weight Lost: _____ lbs
Reason for Stopping _____

Please provide details of any previous surgeries or other weight-loss measures you have undergone that were not previously mentioned:

Please list all vitamins, herbs or other dietary supplements you take and how often:

How many times per week do you typically consume "fast food"? _____ times per week

How many times per week do you eat out at dine-in restaurants? _____ times per week

Please list the names/types of the restaurants at which you tend to eat (ex: McDonald's, BBQ, Chinese takeout, etc.):

How many meals per day are prepared and consumed at home? _____ meals per day

How many times per day do you consume "sweets"? _____ per day

Please list the types of sweets you consume and how often: (ex: cookies, ice cream, chocolate, donuts, etc):

How many times *per day* do you consume...

Soda?	Never	1-2	3-5	>5
Diet Soda?	Never	1-2	3-5	>5
100% Fruit Juice?	Never	1-2	3-5	>5
Tea?	Never	1-2	3-5	>5
Sweet Tea?	Never	1-2	3-5	>5
Fruit-flavored drinks?	Never	1-3	3-5	>5
Coffee?	Never	1-3	3-5	>5

What do you usually add to your coffee? _____

Water? Never 1-3 3-5 >5

Please check the condiments that you usually consume *at least 3-5 times per week or more*:

- | | | |
|---|---|---|
| <input type="checkbox"/> Butter | <input type="checkbox"/> Cream-based Salad Dressing | <input type="checkbox"/> Whipped Cream |
| <input type="checkbox"/> Mayonnaise | <input type="checkbox"/> Canola Oil | <input type="checkbox"/> Syrup |
| <input type="checkbox"/> Olive Oil | <input type="checkbox"/> Mustard | <input type="checkbox"/> Honey |
| <input type="checkbox"/> Margarine | <input type="checkbox"/> BBQ Sauce | <input type="checkbox"/> Agave Nectar |
| <input type="checkbox"/> Oil-based Salad Dressing | <input type="checkbox"/> Tabasco Sauce | <input type="checkbox"/> Other; please specify: _____ |

How many times *per day* do you consume vegetables?

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> I do not consume vegetables | <input type="checkbox"/> 1-2 times per day | <input type="checkbox"/> 3-5 times per day | <input type="checkbox"/> >5 times per day |
|--|--|--|---|

What are your favorite types of vegetables to consume? _____

How many times *per day* do you consume fruits?

- I do not consume fruits
- 1-2 times per day
- 3-5 times per day
- >5 times per day

What are your favorite types of fruits to consume? _____

How many times per day do you consume meat?

- I do not consume meat
- 1-2 times per day
- 3-5 times per day
- >5 times per day

What are your favorite types of meats to consume? _____

If you are a vegetarian or vegan, what are your sources of protein in your diet?

Do you consume alcohol? Yes No

If yes, how often?

- Never
- 1-2 times per week
- 3-5 times per week
- Daily

What type of alcoholic drinks do you usually consume?

- Beer
- Wine
- Liquor
- Mixed Drinks

Do you smoke? Yes No

If yes : _____pack(s) per day

Please indicate which dieting barriers apply to you most:

- Portion sizes
- Stress eating
- Work schedule
- Not feeling full
- Lack of knowledge regarding "healthy foods" or diets
- Other; please specify: _____
- Snacking
- Late night hunger
- Binge eating
- Financial barriers
- Emotional eating
- Temptations within household

Do you exercise? Yes No

If yes, please list the types of physical activity below:

Physical Activity	How Many Times Per Week	How Many Minutes

If no, please describe any physical disabilities or other reasons that would prevent you from participating in a fitness routine:
