

**Bariatric Preoperative Nutrition Assessment**

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Age: \_\_\_\_\_ Male Female

Circle one: Lap-band      Roux-en-Y (Gastric By-pass)

Why do you want to have this surgery? \_\_\_\_\_

\_\_\_\_\_

Who is your primary support person? \_\_\_\_\_

Are they supportive of you having the surgery?    Yes    No

How do you think the surgery will affect your life? \_\_\_\_\_

\_\_\_\_\_

What advantages do you see for having the procedure? \_\_\_\_\_

\_\_\_\_\_

What disadvantages do you see for having the procedure? \_\_\_\_\_

\_\_\_\_\_

List any vitamins or herbal medications you currently take: \_\_\_\_\_

\_\_\_\_\_

**Weight History:**

At what weight have you felt your best or do you think you would feel your best? \_\_\_\_\_

How much weight would you like to lose? \_\_\_\_\_

How does your weight affect your daily activities? \_\_\_\_\_

\_\_\_\_\_

How do you think your life would change if you could reach your weight goal? \_\_\_\_\_

\_\_\_\_\_

Why do you want to lose weight at this time? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List your past weight lost attempts (examples: diets, weight loss pills, personal trainer, Weight Watchers, etc):

Write down a timeline of your weight loss and gain from high school to present:

Exercise History:

How physically active are you?

Very Active      Active      Average      Inactive      Very Inactive      Other \_\_\_\_\_

What do you do for physical activity and how often do you do it? \_\_\_\_\_

\_\_\_\_\_

Is there anything that prevents you from being physically active? \_\_\_\_\_

What do you like to do for fun? \_\_\_\_\_

Are you committed to incorporating physical activity into a long-term weight management program?

Yes    No

\_\_\_\_\_

Food:

Do you understand the consequences of not complying with the food guidelines after surgery?    Yes    No

Do you understand the long-term changes in food intake that will be necessary for all occasions after surgery for the rest of your life?    Yes    No

Can you tell when you are physically full?    Yes    No

Do you know if you are eating or drinking for reasons other than hunger or thirst?    Yes    No

\_\_\_\_\_

Diet History:

Please write down when, what and how much you usually eat and drink during a typical day, starting with when you get up.

Please add any other information that you feel may be relevant.

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