

**Pre-Surgical Nutrition Assessment
for Bariatric Patients**
(current as of June, 2008)

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 U.S.C. 55, Medical and Dental Care, and E.O. 9397. **PURPOSE:** Information will be used to assist health providers in assessing personal health and dietary history of patients. **ROUTINE USES:** Records from this system of records may be disclosed for any of the blanket routine uses published by the Air Force. **DISCLOSURE:** Furnishing the information is voluntary.

Name (last,first,MI) _____ Today's date: _____

Sponsor's SSN: _____ Male / Female

Ht: _____ Current wt: _____ Age: _____

Home phone: _____ May we call you at home? Yes No

Work phone: _____ May we call you at work? Yes No

Email: _____

Are you taking any of the following medications/herbal products?

- | | | |
|--|--|---|
| <input type="checkbox"/> Coumadin (Warfarin) | <input type="checkbox"/> Eldepryl (Selegiline) | <input type="checkbox"/> Ephedra (Ma Huang) |
| <input type="checkbox"/> Nardil (Phenelzine) | <input type="checkbox"/> Zyvox (Linezolid) | <input type="checkbox"/> Androstendione |
| <input type="checkbox"/> Matulane (Procarbazine) | <input type="checkbox"/> Levodopa (L-DOPA) | <input type="checkbox"/> Caffeine |
| <input type="checkbox"/> Parnate (tranylcypromine) | <input type="checkbox"/> Sinemet (Carbidopa) | (in supplement) |
| <input type="checkbox"/> Furoxone (Furazolidone) | <input type="checkbox"/> Isoniazid (INH) | |

Have you ever received diet/drug interaction education for this? Yes No

Are you taking any over-the-counter dietary supplements such as vitamins or herbal products (weight loss products included)? Yes No _____

Which of the following comorbidities have you been diagnosed with?

Hypertension Heart Disease Congestive Heart Failure

Hyperlipidemia (high chol/TG) Arthritis Diabetes GERD (reflux)

Stress Urinary Incontinence Pseudotumor cerebri Gallstones

Weight Related Arthropathy (pain in wt bearing joints) Sleep Apnea

Have you ever been treated or are you now being treated for:

Cancer Kidney Disease Liver Disease Bowel Disease

Do you smoke? Yes No Amount: _____

Do you drink alcohol? Yes No Type: _____ Amount: _____

Your preferred learning style? Reading Video Lecture Hands-on None

Do you have any communication barriers? Hearing Speech Language None

Do you have any preferences or circumstances that may affect the amount or type of food you eat? (for example - cultural, religious, economic concerns)

Yes No _____

Do you have any conditions or special needs that may affect the amount or type of food you eat? (for example - health conditions, vegetarian, lactose intolerance, food allergies, gluten intolerance or celiac sprue)

Yes No _____

Which type of surgery are you hoping to have? _____

Where will the surgery be performed? _____

How long have you been contemplating having weight loss surgery? _____

If you have weight loss surgery, what factors are present that you believe will help you succeed at weight loss? (family, support, etc.)

If you have weight loss surgery, are there any barriers present that may make losing weight difficult? (lack of support, occupation, etc.)

What do you think is the biggest change you will have to adjust to following weight loss surgery? (eating regular meals, taking vitamins, etc.)

Which have you previously tried in your attempt to lose weight:

PROGRAM	YEAR	HOW LONG	AMOUNT LOST
Dietitian			
MD Supervised Medifast Optifast Bariatric Surgery Other:			
Non-MD Supervised Weight Watchers Nutri-system Jenny Craig TOPS Other:			
Pharmaceuticals / Prescription Drugs Phen-Phen Redux Xenical Other:			
Other Self-monitored diet (Atkins, South Beach)			

How do you think weight loss surgery will help you in ways that other programs or medications (supervised and unsupervised) have not?

How would you describe your current job/daily activity:

- _____ Sedentary (desk job/ home most of day)
- _____ Slightly active (run errands but no planned exercise)
- _____ Active (on your feet most of the day)
- _____ Strenuous (lifting on job / strenuous work daily)

Do you currently have a routine exercise program? Yes No

Describe: _____

What barriers are keeping you from exercising now? (lack of time, skill, etc.)

Once surgery is done and your MD clears you for exercise, what do you plan to do?

What barriers would keep you from exercising following surgery?

Please put an "X" next to your personal food preferences:

Candy _____	Fried Foods _____	Steak/Red Meat _____
Chocolate _____	Fast foods _____	Pizza _____
Cakes _____	Seafood _____	Dairy products _____
Chips _____	Vegetables _____	Fruits _____
Cookies _____	Fruit juice _____	Nuts _____

How many meals do you typically eat per day: _____

What would cause you to skip a meal? _____

Do you eat between meals? Yes No Favorite snacks: _____

Do you use caffeinated products? Yes No
_____ Cups coffee per day _____ Carbonated drinks per day

How many sodas do you typically drink each day: _____ Diet or Regular

Please list the foods and beverages you usually eat on a daily basis. Be as specific as possible and try to list amounts:

Breakfast **Snack** **Lunch** **Snack** **Dinner** **Snack**

What specific questions do you hope to have answered at your appointment with the dietitian today?