Mercer Health Lap Band Surgery Nutrition Questionnaire

SOCIOECONOMIC

Name: ____ Age:

Occupation: ________________________________ Years of school completed

Do you have trouble reading or seeing? ☐ Yes ☐ No
Explain:

Do you have trouble hearing? ☐ Yes ☐ No
Explain:

SUPPORT SYSTEMS

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Number in Household: ___________ List names & relationship:

Primary Support Person (list name and relationship):

CULTURAL FACTORS

Do you have any language barriers, religious observations, or other personal customs that may cause conflicts to care? ☐ Yes ☐ No
Explain:

STRESS

Do you have a lot of stress in your life?

☐ More than average ☐ Average ☐ Less than average

Explain:

Describe coping mechanisms:

How do your moods/stress affect your eating?

EXERCISE HISTORY

How physically active are you?

☐ Very Active ☐ Active ☐ Average ☐ Inactive ☐ Very Inactive

Describe your physical activity:

Activity	Number of times per week	How long	Problems
☐ Walking			
☐ Bicycling			
☐ Swimming			
☐ Water exercises			
☐ Golf - walking			
☐ Golf - cart			
☐ Tennis			
☐ Aerobics			
☐ Weight training			
☐ Other:			

Do you ever exercise excessively or compulsively to lose weight? ☐ Yes ☐ No

Explain:

Is there anything that prevents you from being physically active? ☐ Yes ☐ No

Explain:

What do you like to do for fun?

Who with?

Are you committed to incorporating physical activity into a long-term weight management program? ☐ Yes ☐ No Explain:

WEIGHT HISTORY

What is your current weight? ______________ What is your current height?

Highest adult weight: ___________________________ Date:

Lowest adult weight: ___________________________ Date:

What would you like to weigh?

Describe your weight pattern: Try to remember periods in your life when you were overweight or underweight. **Complete the parts you can remember.** If you can't remember specific weights, you can list clothing sizes or describe how you remember feeling about your weight during that time period. Briefly describe any methods you used to lose weight in that period. (i.e.: type of diet, medication, exercise). Also list any significant life events that you feel were related to weight gain or loss (i.e.: prom, dating, weddings, pregnancy, illness, accidents, deaths, reunions, sports, work, etc).

Age	Approx. Weight	Methods used to gain or lose weight	Related events
Birth			
0-5			
6-10			

11-15			
16-20			
21-25			
26-30			
31-35			
36-40			
41-45			
46-50			
51-55			
56-60			
61-65			
66-70			
70+			

How would you describe your current weight?

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?

On previous diet attempts, in which you achieved weight loss, why do you feel you regained weight? (ie: hunger, boredom, etc.)

What do you feel are your barriers to keeping weight off?

☐ Lack of motivation

☐ Lack of knowledge about nutrition

☐ No support from family or friends

☐ Time issues

☐Cost

☐ Physical hunger

☐ Emotional eating

☐ Frustration with lack of results

☐ Others:

What are the attitudes of the following people about the possibility of you having lap band surgery?

	Negative	**Indifferent**	**Positive**	**Unaware of plans**
Spouse				
Children				
Parents				
Friends				
Employer				
Co-workers				

How will these attitudes affect you?

EATING HABITS

How many meals do you usually have per day?

Do you frequently skip meals? ☐ Yes ☐ No
Explain:

Who plans the meals?
Who cooks? ____________________________ Who shops?

How often do you snack between meals? ☐ 0 to 1 ☐ 2 to 4 ☐ 5 to 7 ☐ Other

What triggers you to eat?

☐ Hunger ☐ Boredom ☐ Depression ☐ Loneliness ☐ Lack of control

☐ Anger ☐ Family gatherings ☐ Social situations ☐ Other:

How many times do you eat out per week?

Which meal(s) do you eat out most frequently? ☐ Breakfast ☐ Lunch ☐ Supper

Do you have any food allergies or intolerances? ☐ Yes ☐ No
Explain:

Do you have any strong food dislikes?

Do you have any problems with the following?

Teeth: ☐ Yes ☐ No Chewing: ☐ Yes ☐ No Swallowing: ☐ Yes ☐ No
Explain:

How quickly do you normally eat? ☐ Fast ☐ Moderate ☐ Slow

Do you chew your food thoroughly? ☐ Yes ☐ No ☐ Sometimes

Do you have any special diet needs that you follow now? ☐ Yes ☐ No
Explain:

What are your favorite foods?

Do you drink pop? ☐ Yes ☐ No Type and number of drinks per day:

Do you drink caffeine? ☐ Yes ☐ No Type and number of drinks per day:

Do you drink alcohol? ☐ Yes ☐ No Type and number of drinks per day:

Can you tell when you are physically hungry? ☐ Yes ☐ No

Do you sometimes eat for reasons other than hunger? ☐ Yes ☐ No
Explain:

Can you tell the difference between hunger and thirst? ☐ Yes ☐ No

Do you like to drink water? ☐ Yes ☐ No

Can you tell when you are physically satisfied with the amount of food that you have eaten – not hungry, not over full – but *just right*? ☐ Yes ☐ No

Can you tell when your stomach is "full"? ☐ Yes ☐ No

Can you tell when your stomach is "stuffed"? ☐ Yes ☐ No

Have you ever vomited as a means of weight control? ☐ Yes ☐ No
Explain:

Have you ever used laxatives as a means of weight control? ☐ Yes ☐ No
Explain:

Have you ever experienced periods in which you eat uncontrollably? ☐ Yes ☐ No
Explain:

Do you know how to keep a detailed food and beverage intake log? ☐ Yes ☐ No

Have you read about the food and beverage guidelines you will need to follow after lap band surgery? ☐ Yes ☐ No

Do you have the following equipment? ☐ Blender ☐ Food Processor ☐

Strainer

☐ Measuring cups and spoons

Do you know how to make smooth, blenderized foods? ☐ Yes ☐ No

Do you know how to measure foods and beverages accurately? ☐ Yes ☐ No

Do you understand how to read food labels? ☐ Yes ☐ No

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

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

CONCERNS AND QUESTIONS

What are your biggest concerns regarding "Lap Band" surgery?

How do you think "Lap Band" surgery will affect your life?

What advantages do you see for having the procedure?

What disadvantages do you see for having the procedure?

What questions do you have that you would like to discuss with the dietitian during your next appointment?

Patient Signature: ____ Date:

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