Pre-Surgery History

Name: _____ **Date of birth:** _____

Surgery desired: _____ **Surgeon's name**: _____

Reasons for wanting surgery: _____

_____

_____

Past attempts at weight loss (including weight loss medications):

Type of Program	Dates Followed	Weight Lost

What has made it hard to lose weight and/or maintain weight loss?

_____

_____

_____

_____

Medical history: Place "x" beside conditions you have. Circle if a family member has the condition.

	Asthma		High cholesterol		PCOS
	Heart disease		High blood pressure		Hypothyroidism
	Osteoarthritis		Liver disease		Gout
	Diabetes		Sleep apnea		Other:

Other medical conditions: _____

Height: _____ Current weight: _____

Highest weight ever: _____ Lowest adult weight: _____

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Medications: _____

_____

_____

Vitamin/Mineral or Herbal Supplements: _____

_____

Exercise: Place an "x" by the description that best describes you currently.

	Minimal, sit most of the time		Regular exercise (type):
	Do some activities of daily living such as cooking, cleaning, or errands		Days per week: Minutes each time:
	Sporadic exercise		Unable to exercise due to:

Dietary pattern: Describe a typical day with your eating.

Time	Meal or Snack	Type of Food or Beverage	Amount Consumed

List the beverages you drink on a regular basis: _____

_____

Do you consume alcohol? (circle one) Yes No

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Place an "x" next to your answer. Please answer as honestly as possible. There are no right or wrong answers.

T	F	
		I restrict the type or amount of food I eat.
		I sometimes lose control of how much I eat.
		I feel guilty after eating.
		I make myself sick (vomiting) when I feel uncomfortably full.
		I think about food >50% of my day.

Do you have history of an eating disorder? (circle one) Yes No

Readiness Quiz: The following questions are to help determine if you have adequate knowledge of the dietary changes necessary for surgery. If you do not know an answer, the RD will review the information with you.

1. My daily goal for protein will be: _____ grams
2. I will need to take vitamin/mineral supplements for how long? _____
3. I need to stop drinking liquids _____ minutes before meals and wait _____ minutes after meals to resume drinking liquids.
4. I should drink at least _____ ounces of fluids per day.
5. Which food should you eat first at a meal? _____
6. I should get _____ servings per day of fruits and vegetables after surgery?
7. It should approximately how long to eat a meal after surgery? _____ minutes
8. Which types of beverages should you avoid after surgery (select all that apply)?

__Alcohol __Water __Juice __Diet Soda __Coffee

__Crystal Light __Unsweetened tea __Protein Drinks

9. It is ok to chew gum to fight off hunger after surgery. __True __False
10. I should aim for _____ minutes per day of exercise most days of the week.

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