AM NUTRITION SERVICES

"Providing Tools and Enhancing Skills To Improve Your Nutritional Health"

AM Nutrition Services

Bariatric Pre-Op Nutrition Assessment

Name: _____ **Date of Birth:** _____

Occupation: _____ **Age:** _____ **Sex: M F**

Referred by: _____ **Procedure: Bypass Sleeve LapBand**

Surgeon Name:_____ **Fax Number:**_____ **May we fax surgeon? YES NO**

Circle last year of school attended: 8 9 10 11 12 College/Advanced Degree

Anthropometrics

Present Weight: _____ Height: _____

How much weight would you like to lose? _____

Goal weight: _____ Weight 1 year ago: _____

Social History

Choose one: Married Single Partnered

Who is your primary support person? _____

Are they supportive of you having this surgery: YES NO

AMNS RD section:
(to be filled out by Dietitian)

Current weight: _____

Current BMI: _____

RD Goal BMI: _____

IBW: _____

%IBW: _____

Diagnoses:_____

_____

_____

_____

_____

Do you live alone? YES NO, with_____

Do you do the cooking/shopping? YES NO, done by _____

Family history of overweight/obesity? YES, who_____ NO

Women only: # of pregnancies_____ # of live births: _____ Avg. wt gain: _____

Arrowhead
18001 N. 79th Ave.
Suite A-12
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Metrocenter
10000 N. 31st Ave.
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Avondale
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YES NO (Women only)

☐ ☐ Have you ever been diagnosed with PCOS? (poly-cystic ovarian syndrome)

YES NO (ALL)

☐ ☐ Do you drink alcoholic beverages? If yes, estimate ounces per week_____

☐ ☐ Are you aware that alcohol intake is ***highly discouraged*** after surgery?

☐ ☐ Have you ever smoked cigarettes? If yes, how many per day? _____ Year quit: _____

☐ ☐ Do you smoke marijuana?

Diet History

How many meals per WEEK do you eat out/get take out or otherwise not prepare your own food? ____

Name 2 places where you are most likely to eat out or get take out:

_____ _____

Which of the following weight loss methods have you tried? (Put the # of times each was used)

_____ Weight Watchers, Jenny Craig, etc. _____ Overeaters Anonymous, TOPS, etc

_____ High Protein, Atkins, etc. _____ Counting calories/fat/carbohydrates

_____ Fasting/Modified Fasting _____ Amphetemines _____HCG _____Phen/phen

_____ Laxatives _____Diuretics _____ Meridia _____Xenical _____ Other: _____

Which method was most successful? _____ How much did you lose? _____

What weight did you get down to? _____ How long did you maintain that weight? _____

YES NO

☐ ☐ Have you ever experienced periods of uncontrollable eating (binge)?

☐ ☐ Have you experienced feelings of self-hate, shame and guilt after eating too much?

☐ ☐ Do you ever make yourself vomit or use laxatives after a binge?

☐ ☐ Have you ever received behavioral/psychological support for eating issues?

☐ ☐ Have you ever kept a food/beverage diary?

☐ ☐ Are you willing to keep a food/beverage diary?

☐ ☐ Do you know the difference between hunger and thirst?

☐ ☐ Can you tell when you are full?

Do you eat under the following circumstances? (Circle all that apply)

Sadness Shame Happiness Boredom Anxiety Frustration Anger

Depression Celebration Revenge In bed In the car In front of the TV/computer

Exercise History

YES NO

☐ ☐ Do you exercise three times per week or more?

If yes, list activities: _____

If no, what would you enjoy doing? _____

How many hours/day do you spend watching TV/using the computer? _____

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

General Information

Any previous bariatric education? Circle one: **YES** **NO** If yes, Where/ with whom:

_____

Do you have any nutrition-related questions that you'd like your RD to address at this time?

_____

_____

What is your motivation for undergoing bariatric surgery? Does it relate to any hobbies, interests or enjoyable past-times?

_____

_____

THANK YOU for taking the time to fill out your assessment!

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