Stanford Hospital and Clinics Nutrition Profile

Name: _____ _____ Date: _____
(Last) (First)

Address: _____

Telephone: Day (____)_____ Occupation: _____

Primary Care Doctor's Name: _____

Have you ever had: High Cholesterol? Yes/No, High Blood Sugar? Yes/No, High Blood Pressure? Yes/No

List any medications, vitamins, minerals, herbs and nutritional supplements that you take:

_____

_____

Your Age: _____ Height: ____ft. ____in. Weight: _____ pounds

What is a realistic, healthy weight for yourself? _____

How has your weight changed in the past two years? _____

Who prepares your meals at home? _____

What percent of meals that you eat are prepared at your home? _____

Please indicate your typical intake of the following beverages

Beverage	**How Often? (Daily, Weekly, Monthly, Yearly)**	**How Many Cups or Ounces?**
Whole milk		
Low fat, 2% or reduced fat milk		
Nonfat, skim, or 1% milk		
Juice, fruit drinks, Kool-Aid		
Regular soda		
Wine		
Beer		
Liquor		
Coffee, hot tea, iced tea		
What do you put in your coffee or tea? Sugar Milk Cream Sugar Substitute		

What types of exercise do you do regularly and how much time each week do you spend doing them?

Activity or Exercise	**Times per Week**	**Minutes per Activity**

Physical limitations?_____

Last Name:_____

Why do you want to lose weight?_____

_____

Onset of obesity: age:_____ Highest adult weight and date: _____

Lowest adult weight and date: _____

What methods have you tried to lose weight?

Method or Diet	Length of Time Followed	Amount of Weight Lost

How have you gathered information about the surgery? Do you have a close relative or friend who has had the surgery?

_____

Have you attended the Surgery Informational Session with Dr. Morton? Yes No

Have you attended the Pre-Op Educational Session with the Nurse & Dietitian? Yes No

Do you Binge eat? Yes No Do you wake up and eat in the middle of the night? Yes No

Have you ever tried vomiting to lose weight? Yes No

Have you ever used laxatives to lose weight? Yes No

How many meals do you eat daily? _____ How many snacks do you eat daily?_____

How many minutes does it take you to eat a meal? _____

What causes you to gain weight? _____

_____

How confident are you that you can lose 10% of your weight before bariatric surgery? _____

_____

Who will assist you at home following the surgery?_____

What is your plan for exercise after you have recovered from surgery? _____

_____

Will it be difficult for you to give up drinking alcohol? Yes No

If you are a woman, do you plan to become pregnant? Yes No

Note: Even for those who have a history of infertility, becoming pregnant may be easier with weight loss. However, pregnancy should be avoided until you have maintained a stable body weight for 12 to 18 months or more. Women who wish to become pregnant in the future may benefit from a consult with an obstetrician/gynecologist.

Please record your food intake for two typical days.		
Food Intake Record		
Date:		
Meal	**Food**	**Amount Eaten**
Breakfast:		
Snacks:		
Lunch:		
Snacks:		
Dinner:		
Snacks:		
Exercise:	**Type of Exercise:**	**Number of Minutes:**

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