OCHSNER SURGICAL WEIGHT LOSS PROGRAM
NUTRITION AND EATING HABITS QUESTIONNAIRE

Please complete the information below and bring to your initial consultation with the dietitian. You will be required to attend an additional visit with the dietitian if this packet is not present and completed.

Name ________________________________ Date ________________________________
Clinic Number __________________________ Birth Date __________________________

1. Who prepares the meals in your home? ________________________________

2. How many meals (restaurants, take-out, and fast food) per week do you eat away from home on weekdays? _______ How many breakfasts? _______ Lunches? _______ Evening Meals? _______

3. How many meals (restaurants, take-out, and fast food) do you eat away from home on weekends? _______ How many breakfasts? _______ Lunches? _______ Evening Meals? _______

4. Name the restaurants/fast food where you often eat: ________________________________

5. Do you exercise? No _____ Yes _____ If you do exercise, what do you do? ________________________________ How often do you do it? __________________

6. Is there any reason why you cannot or should not exercise? ________________________________

7. Has your weight changed in the last year? No _____ Yes, I gained _________ pounds

   Yes, I lost _________ pounds

8. What do you think is a realistic weight for you? _________ pounds

9. How long has it been since you were at that realistic weight? ________________________________

10. Have you ever tried medicines to lose weight? No _____ Yes _____
If you have, list the medicines: ____________________________________________

11. What kind of diets have you tried to lose weight? ____________________________________________

12. Have you ever been successful with dieting? No ______  Yes ______

13. What kind of surgeries have you tried to lose weight? ____________________________________________

14. Have you ever used starvation or purging/laxatives to lose weight? No ______  Yes ______

When was the last episode? ____________________________________________

15. Do you currently take vitamins or minerals? No ______  Yes ______

If you do, list them with the amounts that you take: ____________________________________________

<table>
<thead>
<tr>
<th>How many servings do you have per week of the following items?</th>
<th>Less than 1</th>
<th>1-3</th>
<th>4-6 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>candy</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>cake/pie</td>
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<tr>
<td>cookies</td>
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<td></td>
<td></td>
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<tr>
<td>ice cream</td>
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<td></td>
<td></td>
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<tr>
<td>chips</td>
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<tr>
<td>vegetables</td>
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<td></td>
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<tr>
<td>fruits/fruit juice</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>fried foods</td>
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<td></td>
</tr>
<tr>
<td>fast foods</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>sugar added to cereal, coffee, tea, etc</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>punch or lemonade</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>regular soda (12oz serving)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>danish, doughnuts, pastry</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>beer (12oz serving)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>wine (4oz serving)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>hard liquor (1 shot)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>mixed drinks/cocktails</td>
<td></td>
<td></td>
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<tr>
<td>daiquiris</td>
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</tr>
</tbody>
</table>
Three Day Food Record (Include 2 Weekdays and 1 Weekend Day)

<table>
<thead>
<tr>
<th>Weekday (Day #1)</th>
<th>Time &amp; Place</th>
<th>What did you eat and drink? (Include amount)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakfast (1st Meal)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Snack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lunch (2nd Meal)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Snack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dinner (3rd Meal)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Snack</td>
<td></td>
<td></td>
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<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weekday (Day #2)</td>
<td>Time &amp; Place</td>
<td>What did you eat and drink? (Include amount)</td>
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<tr>
<td>-----------------</td>
<td>--------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Breakfast (1st Meal)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Snack</td>
<td></td>
<td></td>
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<tr>
<td>Lunch (2nd Meal)</td>
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<tr>
<td>Snack</td>
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<td></td>
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<tr>
<td>Dinner (3rd Meal)</td>
<td></td>
<td></td>
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<tr>
<td>Snack</td>
<td></td>
<td></td>
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<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weekend (Day #3)</td>
<td>Time &amp; Place</td>
<td>What did you eat and drink? (Include amount)</td>
</tr>
<tr>
<td>-----------------</td>
<td>--------------</td>
<td>--------------------------------------------</td>
</tr>
<tr>
<td>Breakfast (1st Meal)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Snack</td>
<td></td>
<td></td>
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<tr>
<td>Lunch (2nd Meal)</td>
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<tr>
<td>Snack</td>
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<td></td>
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<tr>
<td>Dinner (3rd Meal)</td>
<td></td>
<td></td>
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<tr>
<td>Snack</td>
<td></td>
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</tr>
<tr>
<td>Other</td>
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</tbody>
</table>
Readiness Scale

For each question below, circle the number on the rating scale (1 = not at all likely and 5 = extremely likely) that best describes how ready you are to perform the activity.

*How READY are you to:*

1. Lose weight and improve your health?
   1   2   3   4   5
2. Have weight loss surgery?
   1   2   3   4   5
3. Make permanent changes to your diet/lifestyle?
   1   2   3   4   5

*How CONFIDENT are you in your ABILITY to:*

1. Limit breads, rice, and potatoes?
   1   2   3   4   5
2. Stop drinking sugary drinks?
   1   2   3   4   5
3. Limit sweets?
   1   2   3   4   5
4. Eat green vegetables daily?
   1   2   3   4   5
5. Eat 6 times per day?
   1   2   3   4   5
6. Quit smoking/drinking?
   1   2   3   4   5
7. Increase your physical activity?
   1   2   3   4   5

For more information, call Ochsner Medical Center’s Surgical Weight Loss Program at 504-842-2701.

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