

# Nutrition PREoperative Form

Mount Sinai Program for Surgical Weight Loss  
5 East 98<sup>th</sup> Street, 14<sup>th</sup> Floor, New York, NY 10029

*Sections 1-8 to be filled in by patient*

## Section 1: Patient & Surgery Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Surgeon: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_ Insurance: \_\_\_\_\_

Type of Surgery :  Gastric Bypass  BPD/DS  Lap-band

## Section 2: Height & Weight Information

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Desired Goal Weight: \_\_\_\_\_

What was your highest weight? \_\_\_\_\_ When? \_\_\_\_\_

What was your lowest weight? \_\_\_\_\_ When? \_\_\_\_\_

How long have you been overweight? \_\_\_\_\_

Childhood weight:  Under  Average  Over

Reasons for weight gain: \_\_\_\_\_

## Section 3: Past Medical History

*Please check all that apply:*

- Diabetes  High Cholesterol  Hypertension  Heart Disease  
 Sleep Apnea  Difficulty Breathing  Binge Eating  Anorexia/Bulimia  
 Arthritis  Other \_\_\_\_\_

Is there a family history for obesity or any of the above chronic diseases?  Yes  No

If so, which ones? \_\_\_\_\_

**Section 4: Medications and Supplements**

Please list all the medications you are currently taking: \_\_\_\_\_

\_\_\_\_\_

Please list all the vitamins/minerals/herbal supplements you are currently taking: \_\_\_\_\_

\_\_\_\_\_

Do you take your medication every day as prescribed?  Yes  No

**Section 5: Social History**

Do you currently exercise?  Yes  No

If so, what is your regimen? \_\_\_\_\_

Do you smoke?  Yes  No

Do you drink alcohol?  Yes  No If yes, how often? \_\_\_\_\_

**Section 6: Dietary Restrictions**

Do you have any food allergies?  Yes  No

If yes, please list what you are allergic to: \_\_\_\_\_

Are you lactose intolerant (you don't tolerate milk or milk products)?  Yes  No

Are you kosher?  Yes  No Are you vegetarian?  Yes  No

**Section 7: Food Frequency**

How many times per week do you dine out? \_\_\_\_\_

How many times per week do you eat fast foods? \_\_\_\_\_

Who cooks for you? \_\_\_\_\_ Who goes grocery shopping for you? \_\_\_\_\_

How many times per week do you eat fried food? \_\_\_\_\_

How many times per week do you eat sweets (cookies, cakes, candy, ice cream, chocolate)? \_\_\_\_\_

Do you add butter, margarine, salad dressing, oil or mayonnaise to your food? Please circle which ones.

**Section 7: Food Frequency Continued ...**

Which of the following beverages do you drink?

Regular Soda  Diet Drinks  Juice  Fruit Drinks  Milk  Iced Tea  Tea  Coffee  Water

Do you feel you crave the following foods?  Pasta  Bread  Rice  Cereal  Potatoes

Do you eat fruits and vegetables every day?  Yes  No

How many times per week do you eat cheese? \_\_\_\_\_

How many times per week do you eat yogurt? \_\_\_\_\_

Do you eat red meat, chicken, turkey, fish, tofu, eggs, or nuts every day?  Yes  No

Which of these foods do you prefer? \_\_\_\_\_

What do you perceive as the biggest weakness in your diet? \_\_\_\_\_

**Section 8: Diet History**

*Please indicate the diets you have tried in the past:*

| Diet   | Specific Dates | Amount of Weight Loss | Did you regain the weight? |
|--|----------------|-----------------------|----------------------------|
| <input type="checkbox"/> Weight Watchers   |                |                       |                            |
| <input type="checkbox"/> Atkins  |                |                       |                            |
| <input type="checkbox"/> South Beach   |                |                       |                            |
| <input type="checkbox"/> Slim-Fast   |                |                       |                            |
| <input type="checkbox"/> The Zone  |                |                       |                            |
| <input type="checkbox"/> Optifast  |                |                       |                            |
| <input type="checkbox"/> Nutrisystem   |                |                       |                            |
| <input type="checkbox"/> Jenny Craig   |                |                       |                            |
| <input type="checkbox"/> Richard Simmons   |                |                       |                            |
| <input type="checkbox"/> Worked with Nutritionist  |                |                       |                            |
| <input type="checkbox"/> Prescription Medications<br>Indicate which ones:<br><input type="checkbox"/> Fen/Phen<br><input type="checkbox"/> Meridia<br><input type="checkbox"/> Xenical (Orlistat)  |                |                       |                            |
| <input type="checkbox"/> Over-The-Counter Diet Pills<br>Indicate which ones:<br><input type="checkbox"/> Dexatrim<br><input type="checkbox"/> Trim Spa<br><input type="checkbox"/> Metabolife<br><input type="checkbox"/> Hydroxycut<br><input type="checkbox"/> Xenadrine<br><input type="checkbox"/> Stacker |                |                       |                            |
| <input type="checkbox"/> Other<br>Indicate which diet:   |                |                       |                            |

***You may stop here. Thank you for completing this form.***