

Rienstra Clinic Bariatric Services

Name: _____

Date _____

These questions required for weight-loss treatment are in addition to our standard health history form.

Present Status:

1. Are you in good health at the present time to the best of your knowledge? Yes No
2. Are you under a doctor's care at the present time? Yes No
If yes, for what? _____
3. Have you ever had
Diabetes? Yes No
Heart Attack? Yes No
Glaucoma? Yes No
4. Has any blood relative ever had any of the following:
Glaucoma: Yes No Who: _____
Epilepsy: Yes No Who: _____
Kidney Disease: Yes No Who: _____
Tuberculosis: Yes No Who: _____

Nutrition Evaluation:

1. Present Weight: _____ Height (no shoes): _____ Desired Weight: _____
2. In what time frame would you like to be at your desired weight? _____
3. Birth Weight: _____ Weight at 20 years of age: _____ Weight one year ago: _____
4. What is the main reason for your decision to lose weight? _____
5. When did you begin gaining excess weight? (Give reasons, if known): _____

6. What has been your maximum lifetime weight (non-pregnant) and when? _____
7. Previous diets you have followed: _____ Give dates and results of your weight loss: _____

8. Is your spouse, fiancée or partner overweight? Yes No
9. By how much is he or she overweight? _____
10. How often do you eat out? _____
11. What restaurants do you frequent? _____

12. How often do you eat "fast foods?" _____

13. Who plans meals? _____ Cooks? _____ Shops? _____

14. Do you use a shopping list? Yes No

15. What time of day and on what day do you shop for groceries? _____

16. Food allergies: _____

17. Food dislikes: _____

18. Food you crave: _____

19. Any specific time of the day or month do you crave food? _____

20. Do you drink coffee or tea? Yes No How much daily? _____

21. Do you drink cola drinks? Yes No How much daily? _____

22. Do you drink alcohol? Yes No

What? _____ How much? _____ Weekly? _____

23. Do you use a sugar substitute? _____ Butter? _____ Margarine? _____

24. Do you awaken hungry during the night? Yes No

What do you do? _____

25. What are your worst food habits? _____

26. Snack Habits:

What? _____ How much? _____ When? _____

27. When you are under a stressful situation at work or family related, do you tend to eat more? Explain:

28. Do you think you are currently undergoing a stressful situation or an emotional upset? Explain:

Name _____

29. Smoking Habits: **(answer only one)**

- You have never smoked cigarettes, cigars or a pipe.
- You quit smoking _____ years ago and have not smoked since.
- You have quit smoking cigarettes at least one year ago and now smoke cigars or a pipe without inhaling smoke.
- You smoke 20 cigarettes per day (1 pack).
- You smoke 30 cigarettes per day (1-1/2 packs).
- You smoke 40 cigarettes per day (2 packs).

30. Typical Breakfast

Typical Lunch

Typical Dinner

Time eaten: _____

Time eaten: _____

Time eaten: _____

Where: _____

Where: _____

Where: _____

With whom: _____

With whom: _____

With whom: _____

31. Describe your usual energy level: _____

32. Activity Level: **(answer only one)**

- Inactive—no regular physical activity with a sit-down job.
- Light activity—no organized physical activity during leisure time.
- Moderate activity—occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
- Heavy activity—consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week.
- Vigorous activity—participation in extensive physical exercise for at least 60 minutes per session 4 times per week.

33. Behavior style: **(answer only one)**

- You are always calm and easygoing.
- You are usually calm and easygoing.
- You are sometimes calm with frequent impatience.
- You are seldom calm and persistently driving for advancement.
- You are never calm and have overwhelming ambition.
- You are hard-driving and can never relax.

34. Please describe your general health goals and improvements you wish to make: _____

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.