**Stanford Hospital and Clinics Nutrition Profile**

Name:

(Last) (First)

Date:

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***

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| **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?***

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

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