Mehta Bariatric Center
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Name: _____

NUTRITION QUESTIONNAIRE

If you attempted to lose weight in the past, please answer the following questions (many insurance companies want to know that efforts have been made to lose weight):

- **Since when have you been overweight?** _____
- **When you lose weight, do you always regain it?** _____
- **Do you usually gain back more than you lose?** _____
- **What was the biggest loss in pounds you had and how long did it take to regain weight?**
  _____

Insurance companies request the period you have been engaged in attempts to lose weight and professionals you've consulted. So please answer the following accordingly.

- **Have you participated in commercial weight loss programs?**
  If yes, please set forth how long you participated in the program, amount of weight loss and period of maintaining weight loss:

Program	Duration of Program	Total Weight Loss	Duration of Loss
Atkins			
Weight Watchers			
Richard Simmons			

Nutrisystem			
Slimfast			
Jenny Craig			
Susan Powter			
Overeaters Anonymous			
Health Spas			
Gym/Exercise Program			
Others			

o Have you tried various calorie and fat-reduction diets, "fad" diets or diets which required the purchase of books or tapes? If yes, please list._____

_____

_____

o Please list any diets you've tried within the last 6 months and their result

_____

_____

_____

o Please list any diets you've tried within the last 2 years (not mentioned above) and their result.

_____

_____

_____

o Have you been involved in medically or professionally supervised programs? If so, please list. (ex: Optifast, Medifast, etc)

Doctor/Nutritionist	**Type of Program**	**Duration**	**Outcome**

o Have you been prescribed weight loss medications like Phen-Fen or Redux?

If yes, please answer the following:

Medication	Duration of Use	Weight Loss	Duration of Loss	Reason for discontinuing

o **24 Hour Intake Recall (Typical Day):**

Breakfast:

_____

Lunch:

_____

Dinner:

_____

Snacks: A.M.

_____

P.M.

_____

Overnight eating:

_____

High Caloric Liquids: (i.e. regular soda, sweetened iced tea, fruit juices, fruit punches, etc.):

_____

Alcohol: (if yes, how often?)

_____

Sweets:

_____

Salty Snack items:

_____

Fried/Fast foods:

_____

Pizza:

_____

Binges:

_____

- **<u>Have you had psychological or psychiatric counseling for weight loss or problems associated with loss</u>?** π Yes π No

If yes, please describe, and list the name of counselor with address and telephone number.

_____
_____
_____

o **Do you feel that your weight affects your life?**

- Physically: 1) How do you manage ordinary chores/activities of daily life?

  _____
  _____

  2) Do you feel restricted in participating in recreational activities?

  _____
  _____

- Socially: Does your weight affect your relationship with family and friends? If yes, please describe:

  _____
  _____

- Financially: Does your weight affect your ability to work?

  _____
  _____

- Other: _____