

Name: _____ DOB: _____ Date: _____

Nutrition Assessment Questionnaire for Postsurgical Clients in Maintenance Phase

Date of surgery: _____

Who was your surgeon? _____

Which procedure did you have? Gastric Bypass Gastric Band

Height: _____ Today's weight: _____ Total weight loss since surgery: _____

1. List illnesses or medical conditions diagnosed before weight-loss surgery:

2. List medications taken before weight-loss surgery:

3. List current illnesses or medical conditions:

4. List medications currently taken:

5. Do you have a protein food at most meals or snack? No Yes

6. Do you drink liquids with meals? No Yes (list amount) _____

7. Do you drink carbonated beverages? No Yes (list amount) _____

8. Do you drink alcohol? No Yes (list amount) _____

9. Are you taking a multivitamin with minerals/iron daily? No Yes (list type) _____

10. Are you taking a calcium supplement daily? No Yes (list type) _____

11. List other vitamins or supplements that you take:

12. List foods/beverages that your body does *not* tolerate:

13. Do you exercise regularly? No Yes (list types of activity)

14. How many days a week do you exercise? _____

How many minutes per session? _____

Per day? _____ Per week? _____

15. Are you having difficulty adjusting to diet and healthy lifestyle changes? No Yes (explain)
