Please Note: There is a $25 fee all individual nutrition consults. If both sides of this form are not completed at the time of your visit, your appointment will be rescheduled.

Name: ______________________ DOB: ____________ Appointment Date: ____________

FOOD FREQUENCY QUESTIONNAIRE (Complete and bring to your appointment with the Dietitian)

1. Circle the dairy products that you eat:
   - Cheese
   - Cottage Cheese
   - Pudding
   - Yogurt/Greek Yogurt
   - Custard
   - Ice cream
   - Frozen yogurt

2. Circle the protein sources that you eat:
   - Beans
   - Chicken
   - Eggs
   - Fish
   - Ground Beef
   - Ham
   - Nuts
   - Pork
   - Shrimp
   - Soy protein
   - Beef/Steak (≥ 90% lean)
   - Tofu
   - Turkey
   - Protein shakes or bars

3. Starches:
   - How many slices of bread do you eat a day? ______
   - How many meals include potatoes, pasta or rice per week? ______
   - Circle if you eat: Cooked/hot cereal or Dry/cold cereal

4. Do you eat fruits and vegetables every day? Yes No

5. How many times per week do you eat high calorie foods (fried foods, chips, mayo, butter, pizza, etc)? ______

6. How many teaspoons of table sugar do you use per day (1 packet = 1 teaspoon)? ______
   - Which sugar substitute do you use? None Splenda Sweet-n-low Equal Stevia

7. How often do you eat sweets (cookies, cakes, candy, ice cream, chocolate, etc)? ______ times/week

8. How many meals a week do you eat away from home? ______ meals
   - Circle the type of food establishments?
     - Buffet
     - Fast food
     - Chinese
     - Pizza
     - Family restaurant
     - Work/school cafeteria
     - Other ______

9. How much water do you drink each day? ________ ounces


11. Circle each beverage that you drink:
    - Regular Coffee/Decaf Coffee
    - Regular Hot tea/ Decaf Hot tea
    - Sweetened Iced Tea
    - Diet Iced Tea
    - Fruit juice
    - Vegetable juice
    - Milk, what kind? ________


13. Do you eat meals every day? Yes If no, how many meals do you eat a day? ________

14. Do you snack during the day? Sometimes Always Never
    - What do you snack on and how much? ________

15. Do you have a tendency to: ___ Binge Eat ___ Eat when stressed ___ Eat late at night
    ___ Eat when not hungry or bored ___ Graze ___ Skip meals ___ Drink with meals
    ___ Eat a meal in less than 15 minutes

16. Who does the grocery shopping/food preparation? ___Self ___Spouse ___Other ______

17. What are you currently doing for physical activity? ________
    - For how many minutes? ________ How many days per week? ________

18. Name 3 things in your current diet you will be concerned about after surgery:

19. On a scale of 1 (low) to 10 (high) how compliant with the after surgery recommendations do you think you will be?
    1 2 3 4 5 6 7 8 9 10

20. What changes have you made to your diet or lifestyle since starting the classes?

21. Which surgery are you interested in? Gastric Bypass Sleeve Gastrectomy Gastric Band

22. How much weight do you expect to lose as a result of weight loss surgery?
    - Less than 50 lbs.  ☐ 50-100 lbs.  ☐ 100-150 lbs.  ☐ More than 150 lbs.
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To prepare you for the post-op diet complete a 1 day sample menu for each of the diet stages. Use appropriate foods and portion sizes for each stage. Also, calculate the amount of protein you will eat each day. Refer to the handouts from the *Diet and Meal Planning* class to help you complete this assignment.

<table>
<thead>
<tr>
<th>Clear Liquids</th>
<th>Full Liquids</th>
<th>Pureed Foods</th>
<th>Soft Foods</th>
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<tr>
<td><strong>Breakfast</strong></td>
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</tbody>
</table>

Grams of Protein eaten: ____________________
Ounces of fluid drank: ___________ ounces

Grams of Protein eaten: ____________________
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