Hartford HealthCare
The Hospital of Central Connecticut

Patient Name: _____

Date of Birth: _____

Date: _____

PRE-EVALUATION for Weight Loss Surgery
Outpatient Nutrition Center

- Please list any food allergies or intolerances you have:
  _____
- Please list any foods you exclude due to vegetarianism, or religious or cultural restrictions:
  _____
- Do you drink alcohol? YES ☐ NO ☐ How often? _____ How much? _____
- Do you currently smoke tobacco, marijuana, or vape? YES ☐ NO ☐
- Have you ever used any of the following to control your weight? (check all that apply) ☐ Binging and purging ☐ Binging followed by food restriction
  ☐ Diuretics ☐ Laxatives ☐ Vomiting ☐ None of the above
- Have you ever been diagnosed with an eating disorder?
  If yes, please describe when, and if and you had treatment:
  _____
- Over the past month I exercised an average of _____ times per week.

Type of exercise: _____ Number of minutes per session: _____

- Do you have any physical problems that limit your activity? YES ☐ NO ☐

If yes, please describe: _____

- Do you have any eating or digestion problems?

☐ Chewing ☐ Swallowing ☐ Diarrhea ☐ Constipation ☐ Other: _____

- Within the past 12 months, I worried whether my food would run out before I/we had money to buy more: YES ☐ NO ☐
- Within the past 12 months, the food purchased did not last and I/we did not have money to buy more: YES ☐ NO ☐

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Medical History

Height _____ Weight _____ Any recent changes in weight? ☐ Yes ☐ No

Comment: _____

For how many years have you been at your current weight? _____

What would you consider to be a healthy weight for you? _____

What is the highest you have ever weighed? _____

Please check any medical history: ☐ Arthritis ☐ High Cholesterol
☐ High Blood Pressure ☐ Stroke ☐ Depression ☐ Kidney Disease
☐ Thyroid Disorder ☐ Diabetes ☐ Neuropathy
☐ Heart Disease ☐ Sleep Apnea ☐ GERD ☐ Cancer
☐ Lung Disease ☐ Prediabetes ☐ Other (please list):

_____

_____

Diet/Nutrition Information

1. How many people live in your household? _____ Ages _____

2. Who usually does the cooking? _____ Shopping? _____

3. Do you currently follow any type of meal plan (ex. Weight Watchers, low cholesterol, or low sodium? If yes, please describe: _____

4. Do you take vitamins, minerals, herbs, protein, or any other food or nutritional or supplements? ☐ Yes ☐ No
Please list: _____

5. How many times per week do you eat away from home/get take-out or order in? _____

6. In which type of restaurant do you usually eat or take out?
(mark: F=Frequently, O= Occasionally, N=Never)

☐ Fast Foods (burgers, subs, pizza)
☐ Buffets
☐ Sit-down restaurants (types: _____)
☐ Sweets/dessert or coffee shops

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7. Rate your appetite: ☐ Good ☐ Fair ☐ Poor

8. Do you regularly skip meals? ☐ Yes ☐ No

If yes, which meals do you skip most often? _____

9. Where do you do most of your eating?

☐ Table ☐ In front of the T.V. ☐ In the car ☐ Other: _____

10. Which sources of protein do you eat? (please check all that apply)

☐ Chicken ☐ Beef ☐ Pork ☐ Turkey ☐ Fish/Shellfish ☐ Eggs

☐ Tofu ☐ Cheese ☐ Soybeans ☐ Beans (kidney, black, chickpeas)

☐ Egg whites/substitutes ☐ Greek/protein yogurt ☐ Cottage cheese

☐ Nuts ☐ Peanut butter ☐ Cow's milk/Lactaid ☐ Protein drinks/powders

11. What kind of vegetables do you eat (if any)? _____

_____

12. What kind of fruits do you eat (if any)? _____

_____

13. What types of foods do you usually snack on? (examples: fruit, potato chips, candy, cookies, crackers, pretzels, cereal, soda, sandwiches, etc.)

_____

_____

14. What types of beverages do you usually drink? _____

_____

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Please write down a TYPICAL day of eating.

Meal or Snack	Time	What did you eat/drink, and how much?
Breakfast/1st Meal		
Midmorning Snack		
Lunch/2nd Meal		
Afternoon Snack		
Dinner/3rd Meal		
Nighttime Snack		

Social History

15. What are your usual work hours? _____

16. Do you feel that you have an excessive amount of stress in your life?
☐ Yes ☐ No

17. Educational level completed (please circle the appropriate number):

Grade School:	High School:	College:	Graduate: School
1 2 3 4 5 6 7 8	9 10 11 12	13 14 15 16	17 18 19 20+

18. Describe the present support system that you rely upon (circle any/all that apply):
☐ Church ☐ Co-worker ☐ Family ☐ Friends ☐ Spouse ☐ Other:

19. What is motivating you to choose weight loss surgery?

_____

_____

_____

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Weight Loss History

20. Which of the following unsupervised diets have you tried? (please check all boxes that apply)

☐ High protein ☐ Hypnosis ☐ Low carb ☐ Atkins

☐ Low fat ☐ Calorie-Control ☐ Keto ☐ Richard Simmons

☐ Scarsdale ☐ SlimFast ☐ Herbalife ☐ Other: _____

21. Which of the following supervised diets have you tried? (please check the boxes that apply)

☐ Diet center ☐ Nutrisystem ☐ Overeaters anonymous

☐ Jenny Craig ☐ Optifast ☐ Weight Watchers

☐ Pounds ☐ Medi Weight Loss ☐ Other: _____

22. Please check the boxes of any weight loss medications that you have ever taken.

☐ Semaglutide/Ozempic/Wegovy/Rybelsus ☐ Dulaglutide/Trulicity ☐ Alli

☐ Tirzepatide/Zepbound/Mounjaro ☐ Topamax/Topiramate ☐ Metformin

☐ Phentermine ☐ Fen-Phen ☐ Hydroxycut ☐ Other: _____

23. What reason do you feel contributes to you being overweight? (Check all that apply)

☐ Inactivity ☐ Over Consumption ☐ Genetics

☐ Emotional eating ☐ Poor food Choices ☐ Other: _____

Thank you for taking the time to fill out this form.
We look forward to meeting with you.