Bariatric Questionnaire

Patient Name: _____ DOB: _____ Date: _____

Type of Bariatric Surgery: _____ Date of Surgery: _____

Previous Bariatric Surgery? _____

Any requirements for treatment before surgery? Weight Loss _____ Dietician _____

Other _____

Typical: Breakfast	Lunch:	Dinner:	Snack:	Daily Water/Fluids:

Weight:

Current _____

Highest _____ When? _____

Lowest _____ When? _____

Goal Weight: _____

Previous Weight Loss Programs/Diets?

Medications for weight loss?

Exercise Attempts?

Family History of Obesity (others)?

Expectations of Bariatric Surgery?

Plan for support/assistance after surgery?