AKKARY
Surgery Center

1100 Fort Pierpont Drive, Suite 101 Morgantown, WV 26508
Phone: 304-241-1100 www.yourdreambody.com Fax: 304-983-8800

NUTRITIONAL EVALUATION
BARIATRIC ASSESSMENT & PRE-SURGICAL EDUCATION REPORT

Date: _____ Counseling Time: _____

Patient Name: _____ DOB: _____ Age: _____

Reason for seeking bariatric surgery at this time? _____

_____

Your reason for expected success at this time? _____

_____

WORK, SOCIAL & CULTURAL HISTORY EFFECTING WEIGHT ISSUES:

Occupation:_____ Support system/significant others in place? **Y / N**

Other people at home: _____

Do you cook? Y / N Fried: ____ Bake: ____ Grill: ____ Broil: ____ Microwave: ____

Do you eat out? Y / N How many times per week? ____ Most common food choice: _____

Describe your portion size: _____

Describe how often you have food cravings: _____

Beverages consumed in a day and amount:

Coffee_____ Tea _____ Juice_____ Soda _____ Water_____ Milk____Other: _____

Religious or cultural factors effecting weight, food choices, etc: _____

Has infertility been a problem? Y / N Do you have future plans for pregnancy? Y / N

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Name:_____ **Date of Birth:**_____

HISTORY OF WEIGHT & WEIGHT LOSS STRATEGIES:

What was your heaviest weight? _____ Age at that weight? _____

What was your lowest adult weight? _____ Age at that weight? _____

You weight 1 year ago? _____ What is your goal weight after surgery?_____

What are the triggers to your weight gain? _____

What types of weight loss strategies have you tried in the past? Were you successful? _____

_____

Is there a history of an eating disorder? Y / N Please list: _____

Is there a history of mental health issues? Y/ N Please list: _____

REVIEW OF PHYSICAL ACTIVITY & LIMITATIONS:

Current activity and frequency: _____

Lifestyle activity: Sedentary / Active Please explain:_____

What plans do you have to increase your physical activity after surgery? _____

_____

PATIENT'S SIGNATURE: _____**DATE:** _____

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NAME:_____ **DOB:**_____

RN/PHYSICIAN REVIEW

_____ Education materials reviewed

_____ Post operative diet instructions

_____ Pureed bariatric surgery diet (first month after surgery)

_____ Bariatric liquid protein supplements

_____ Discuss dumping syndrome after RYGBP surgery

_____ Discuss vomiting and what is needed to avoid this after surgery

_____ Discuss fluid needs after surgery

_____ Discuss use of alcohol, carbonated drinks and chewing food well

PHYSICIAN ASSESSMENT:

Does patient have realistic expectations for weight loss? Y / N

Does patient verbalize understanding of dietary changes after surgery? Y / N

Does patient verbalize a need for increased physical activity? Y / N

Readiness and motivation: What is your impression of patient's likely level of compliance to dietary and other lifestyle changes required after surgery? _____

_____

_____

PHYSICIAN SIGNATURE: _____ **DATE:** _____