PATIENT DIET HISTORY

WEIGHT HISTORY

Current weight: _____

High school graduation weight: _____

Weight at marriage: _____

Highest adult weight: _____ Year of highest adult weight: _____

Lowest adult weight: _____ Year of lowest adult weight: _____

Personal/family history of weight loss surgery: Y / N, if yes who/what procedure: _____

_____

What do YOU attribute to your personal weight gain/struggles? _____

_____

Diet History	Time frame attempted	Weight lost/regained
Weight Watchers		
Low Carb (Atkins/Keto etc)		
Intermittent Fasting		
Physician/Dietitian managed		
Meal replacement drinks		
Nutri - System		
Jenny Craig		
Calorie Counting/portion reduction		
Portion reduction		
Other/Medications		
Physical Activity History		
None		
None but will start		
Activities of Daily Living		
Walking		
Running		
Treadmill		
Elliptical		
Biking		
Swimming		
Water Aerobics		

Place Patient Label Here

EPIC: ENC level to Patient Intake - Scan
Description: Diet History
Form M2233d (Rev. 07/2020)

What are your barriers to exercise?

_____

_____

CURRENT EATING PATTERNS

Do you regularly skip meals? _____

Do you regularly eat while doing other activities? _____

Do you snack between meals? If so, on what? _____

FOOD/BEVERAGE CHOICES

How many times a week do you eat out? _____

How many sweets/desserts do you eat a week? _____

Indicate your preference for these foods rated from 1 (like very much) to 4 (not at all):

Soda _____

High fat foods _____

Salty _____

Sweet _____

Specifically, what are your favorite foods? _____

_____

Please indicate how much you drink of each:

Water	_____	daily, weekly, monthly, yearly
Pop (Diet/Regular)	_____	daily, weekly, monthly, yearly
Caffeine	_____	daily, weekly, monthly, yearly
Juice	_____	daily, weekly, monthly, yearly
Alcohol	_____	daily, weekly, monthly, yearly

BEHAVIORS

Are you a fast eater? _____

Do you feel the need to clean your plate? _____

Would you say your portions are larger than you would need to be to get full? _____

Do you eat for reasons other than being hungry? _____

Have you ever been diagnosed with an eating disorder? _____

List any barriers, if any, that make it hard for you to eat healthy: _____

_____

MISCELLANEOUS:

Please list any food allergies or intolerances you have: _____

_____

Is there anything else you would like the bariatric team to know about your eating habits:

_____

_____