Please complete this form. The information you share will help the nutritionist have a better understanding of your needs.

1. How will weight loss surgery change your life?
   ______________________________________________________________________
   ______________________________________________________________________

2. Which procedure are you considering?
   □ RNY bypass  □ Lap Band  □ Gastric Sleeve  □ Undecided

3. Please answer the below questions regarding your weight history:
   a. When did you start struggling with your weight? ________________
      ______________________________________________________________________
      ______________________________________________________________________
   b. Do your immediate family members struggle with their weight? □ yes □ no
   c. List previous diet attempts and include pounds lost: ________________
      ______________________________________________________________________
      ______________________________________________________________________

4. How do you typically spend your day? ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________

5. Current Exercise: □ N/A  □ physical limitations__________________________

<table>
<thead>
<tr>
<th>List Activity</th>
<th>Duration of activity?</th>
<th>How many times per week?</th>
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6. List any Food Allergies/Intolerance’s: ________________________________
7. Do you eat when you are not physically hungry? □ a lot □ sometimes □ rarely
8. Do you feel you are an emotional eater? □ yes □ sometimes □ no
9. Do you think about food most of the day? □ yes □ sometimes □ no
10. Does your relationship with food feel out of control? □ yes □ sometimes □ no
11. Do you ever eat a lot of food in a short period of time (i.e. binge)? □ yes □ sometimes □ no

12. How important is it for you to make lifestyle changes? (Lifestyle changes are changes to improve you health, such as adjusting your diet or changing health-related behaviors.)

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13. How ready are you to make lifestyle changes?

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14. What (if any) barriers do you feel will interfere with your ability to make positive lifestyle changes?

__________________________________________________________________________

15. What is your post-op goal weight? ________________________________
   How did you come up with this number? ________________________________

   Thank you!