Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Bariatric Health

Please answer every question.

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

HEALTH STATUS

How would you describe your general health over the past 6 months?
- excellent
- very good
- good
- fair
- poor

Compared to one year ago, how would you rate your health in general now?
- worse
- same
- better

Please mark ALL activities that you are limited in because of your health:
- vigorous activities (running)
- bending, kneeling or stooping
- lifting or carrying groceries
- climbing one flight of stairs
- moderate activities (vacuuming)
- walking more than a mile
- walking several blocks
- bathing or dressing yourself
- flying on a plane
- walking one block

During the past 4 weeks, has your physical or emotional health (such as feeling depressed or anxious) **limited your normal social activities with family and friends?**
- not at all
- slightly
- moderately
- daily

To what extent have you had bodily pain during the past 4 weeks?
- not at all
- slightly
- moderately
- daily

During the past 4 weeks, how much has pain interfered with your normal work (including both work outside the home and housework)**?**
- not at all
- slightly
- moderately
- daily

How much of the time during the past 4 weeks have you:

	DAILY	ALMOST DAILY	OCCASIONALLY	NEVER
Been very nervous?	○	○	○	○
Felt calm, happy and peaceful?	○	○	○	○
Felt full of pep or energy?	○	○	○	○
Felt rested upon awakening?	○	○	○	○
Felt so down in the dumps that nothing could cheer you up?	○	○	○	○
Felt tired or worn out?	○	○	○	○
Had difficulty falling asleep?	○	○	○	○
Suffered from insomnia?	○	○	○	○

Which statement BEST describes your health?
- I am as healthy as anybody I know
- I expect my health to get worse
- I seem to get sick a little easier than other people

Bariatric Health

Please answer every question.

NUTRITION / DIET

How often do you drink protein shakes?
- never
- occasionally
- daily

Do you drink a minimum of 64 oz. of water every day?
- yes
- no

How often do you take the following supplements?

	NEVER	DAILY	OCCASIONALLY
Multivitamin with Iron			
Calcium with vitamin D			
B12			

How often do you have nausea and / or vomiting after meals or eating?
- never
- daily
- each meal

Do you experience any of the following? Mark all that apply.
- nighttime reflux
- sore throat
- wake up choking or coughing at night
- having to sleep elevated or in a reclined position at night

How long are you staying full after meals?
- 30 minutes
- 1-2 hours
- 3-4 hours

Do you attend any of these classes?
- support groups
- nutrition classes

Do you eat breakfast?
- yes
- no

How many meals do you eat a day?
- 1
- 2
- 3
- 4
- graze

Please mark ALL of the following that you cannot eat or have problems with?
- beef
- chicken
- fish
- salad
- fruits
- bread / pizza

Please mark ALL of the following beverages that you drink:
- soda / soft drinks
- juices
- sweet tea
- coffee drinks
- energy drinks
- smoothies / shakes