

Bridges to Weight Management

Initial Meeting with Health Promotion Dietitian

Nutrition Survey

Please fill out prior to appointment with the Registered Dietitian. Questions? Call 621-4304

Date: _____ Where in the network do you work? _____

Name: _____ Employee ID number: _____

Address: _____

Phone numbers: home _____ cell _____ work _____

MD's Name: _____ Bridges Health Coach's name: _____

Are you considering bariatric surgery? Yes _____ No _____

1. What do you hope to accomplish in your visit with the dietitian? _____

2. What are your wellness goals? _____

3. Have you ever tried to lose weight before? Yes / No
a. If yes, what age were you? _____

b. What diet(s) have you tried? _____

4. What was your lowest adult weight? _____ What age? _____

5. What was your highest adult weight? _____ What age? _____

6. Do *you* currently follow a special diet? _____ No If yes, mark below.

_____ diabetes _____ low-fat/low cholesterol _____ low calorie

_____ low salt _____ vegetarian _____ low carbohydrate _____ other _____

7. Does anyone in your *family* have a history of any of the following?

_____ diabetes _____ heart disease _____ high blood pressure

_____ cancer _____ ulcers _____ obesity _____ other _____

8. Do you have any of the above conditions? _____

9. What medications do you take on a regular basis? _____

10. What vitamins, mineral, or herb supplements do you take on a regular basis?

