BARIATRIC PATIENT INTAKE FORM (PIF)

Instructions: Please fill out all of the information by printing your answers. Allow at least 60 minutes to complete this questionnaire. *Note*: There is a 3-day food diary in this form that must be completed before returning it to our office.

Name: _____ Gender*:* _____ Date: _____

Date of Birth: _____ Age: _____ Do you use Avera Chart? ☐ Yes ☐ No

Primary insurance

Company name: _____
Address: _____
City, State, Zip: _____
Insurance phone: _____
Subscriber name: _____
Address: _____
City, State, Zip: _____
Phone: _____
DOB: _____ SSN: _____
Group #: _____
Patient Policy #: _____
Subscriber Policy #: _____
Effective Date: _____

Secondary insurance

Company name: _____
Address: _____
City, State, Zip: _____
Insurance phone: _____
Subscriber name: _____
Address: _____
City, State, Zip: _____
Phone: _____
DOB: _____ SSN: _____
Group #: _____
Patient Policy #: _____
Subscriber Policy #: _____
Effective Date: _____

MEDICATIONS AND SUPPLEMENTS (continued on pg. 2)

PLEASE MAKE SURE TO LIST ALL OF YOUR MEDICATIONS AND OVER THE COUNTER SUPPLEMENTS. YOU'LL NEED TO INCLUDE HOW MUCH YOU TAKE AND WHEN YOU TAKE THEM. THIS INFORMATION IS IMPORTANT AS IT IS USED TO MAKE RECOMMENDATIONS BASED UPON YOUR CURRENT PICTURE OF HEALTH.

Prescription Medication Name	Dosage	How Often?	Taken When?	Reason for Taking?
Example: Clonidine	*.1mg*	*1/day*	*Before Bed*	*High Blood Pressure*

Vitamin/Supplement Name (Please include brand name)	Dosage	Tablet, gummy, liquid, chewable?	How Often?	Taken When?	Reason for Taking?
Example: Vitamin D3	*5000iu*	*1 gel-cap*	*1/day*	*7am*	*Vit D deficiency*

ALLERGIES

Please list any allergies *(including medications, iodine, anesthesia, latex, tape, etc.).*

Allergic to:	Reaction (hives, swelling, difficulty breathing, etc.)

SOCIAL HISTORY

Tobacco Use:

☐ Current every day smoker ☐ Smokeless tobacco user ☐ Never smoker
☐ Current occasional smoker ☐ Former smoker ☐ Vape

Alcohol Use: Do you drink alcohol? ☐ Yes ☐ No

If yes, list type, number of drinks, and frequency:

Beer (12oz): How many? _____ Times per week: _____
Wine (4oz): How many? _____ Times per week: _____
Mixed drinks: How many? _____ Times per week: _____
Hard liquor (1 shot): How many? _____ Times per week: _____

☐ Other (list type and number of drinks): _____

Substance/Drug Use:

☐ None ☐ Hallucinogens ☐ Opiates
☐ Amphetamines ☐ Inhalants ☐ Painkillers
☐ Club/designer drugs ☐ Injection drugs ☐ Tranquilizers/sedatives
☐ Cocaine/crack ☐ Marijuana ☐ Other: _____

PLEASE COMPLETE THIS PORTION OF THE QUESTIONNAIRE BY MARKING ALL THAT APPLY TO YOU.

MEDICAL HISTORY (continued on pages 3 & 4)

Endocrine: ☐ *None of these apply*

☐ Diabetes: ☐ Type 1 ☐ Type 2 ☐ Pre-diabetes ☐ Vitamin D deficiency
☐ Thyroid disease ☐ Graves' disease ☐ Goiter ☐ Hypothyroidism ☐ Hyperthyroidism

Respiratory: ☐ *None of these apply*

☐ Allergies/hay fever ☐ COPD ☐ Pulmonary embolism
☐ Asthma ☐ Pneumonia ☐ Chronic bronchitis
☐ Sleep Apnea/OSA: ☐ C-PAP ☐ Bi-PAP ☐ Other: _____

Cardiovascular: ☐ *None of these apply*

- ☐ Abdominal aortic aneurysm
- ☐ Angina
- ☐ Atrial fibrillation
- ☐ Cardiac arrest
- ☐ Cardiac arrhythmias
- ☐ Cardiomyopathy
- ☐ Carotid stenosis
- ☐ Congenital heart disease
- ☐ Coronary artery disease
- ☐ Deep venous thrombosis
- ☐ Heart failure
- ☐ Heart murmur
- ☐ Heart valve disease
- ☐ Myocardial infarction
- ☐ Palpitations
- ☐ Peripheral edema
- ☐ Peripheral vascular disease
- ☐ Hyperlipidemia/high cholesterol
- ☐ Phlebitis
- ☐ Pulmonary hypertension
- ☐ QTC prolongation
- ☐ Rheumatic heart disease
- ☐ Syncope (fainting)
- ☐ Varicosities
- ☐ Venous Insufficiency
- ☐ Other: _____
- ☐ Hypertension/high blood pressure

Gastrointestinal: ☐ *None of these apply*

- ☐ Chronic constipation
- ☐ Chronic diarrhea
- ☐ Cirrhosis
- ☐ Colitis
- ☐ Colitis – ulcerative
- ☐ Colon polyp
- ☐ Crohn's disease
- ☐ Diverticulosis
- ☐ Diverticulitis
- ☐ Gallstones
- ☐ GERD/acid reflux
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hiatal hernia
- ☐ Inguinal hernia (groin)
- ☐ Irritable bowel syndrome
- ☐ Jaundice
- ☐ Liver disease
- ☐ Pancreatitis
- ☐ Peptic ulcer disease
- ☐ Celiac disease
- ☐ Umbilical hernia (belly button)
- ☐ Ventral hernia
- ☐ Other: _____

Genitourinary: ☐ *None of these apply*

- ☐ BPH/Benign Prostatic Hyperplasia
- ☐ Decreased libido/sex drive
- ☐ Erectile dysfunction
- ☐ Hydronephrosis
- ☐ Hypogonadism
- ☐ Interstitial cystitis
- ☐ Kidney dialysis
- ☐ Kidney disease
- ☐ Kidney failure
- ☐ Kidney stones
- ☐ Overactive bladder
- ☐ Premature ejaculation
- ☐ Past UTI/urinary tract infection
- ☐ Prostate problems
- ☐ Testicular problems
- ☐ Undescended testicle
- ☐ Urinary incontinence
- ☐ Other: _____

Gynecologic (FEMALE ONLY): ☐ *None of these apply*

- ☐ Overactive bladder
- ☐ Endometriosis
- ☐ Infertility
- ☐ PID/Pelvic inflammatory disease
- ☐ PMDD/Pre-menstrual dysphoric disorder
- ☐ PCOS/Polycystic ovarian syndrome
- ☐ Fibroids
- ☐ Other: _____

Hematology: ☐ *None of these apply*

- ☐ Anemia:
- ☐ Iron Deficiency Anemia
- ☐ Megaloblastic/Pernicious Anemia/B Vitamin Deficiency
- ☐ Antithrombin deficiency
- ☐ Chronic anticoagulation
- ☐ Factor V Leiden
- ☐ Hemolytic Uremia Syndrome
- ☐ Lupus anticoagulant
- ☐ MTHFR
- ☐ Protein C deficiency
- ☐ Protein S deficiency
- ☐ Prothrombin II mutation
- ☐ Sickle cell disease
- ☐ Thrombocytopenia
- ☐ Thrombocytosis
- ☐ Transfusion
- ☐ Other: _____

Lymphatic: ☐ *None of these apply*

- ☐ Lymphadenopathy
- ☐ Lymphedema
- ☐ Lymphadenitis
- ☐ Other: _____

Cancer: ☐ *None of these apply*

☐ Blood cancer
☐ Brain cancer
☐ Breast cancer
☐ Cervical cancer
☐ Colorectal cancer
☐ Lymphoma
☐ Musculoskeletal cancer
☐ Neurologic cancer
☐ Oral cancer
☐ Ovarian cancer
☐ Endocrine cancer
☐ Esophageal cancer
☐ Eye cancer
☐ Fallopian tube cancer
☐ Gastrointestinal cancer
☐ Pancreatic cancer
☐ Prostate cancer
☐ Skin cancer
☐ Stomach cancer
☐ Testicular cancer
☐ Genitourinary cancer
☐ Kidney cancer
☐ Leukemia
☐ Liver cancer
☐ Lung cancer
☐ Thyroid cancer
☐ Uterine cancer
☐ Vaginal cancer
☐ Vulvar cancer
☐ Other: _____

Infectious Disease: ☐ *None of these apply*

☐ AIDS / HIV
☐ C-Diff/Clostridium Difficile
☐ Epstein-Barr virus
☐ Meningitis
☐ Tuberculosis
☐ West Nile Virus
☐ MRSA
☐ Vancomycin resistant enterococcus
☐ Hepatitis
☐ Other: _____

Neurologic: ☐ *None of these apply*

☐ Cerebral aneurysm
☐ Cerebral palsy
☐ Stroke
☐ TBI/Traumatic brain injury
☐ Epilepsy
☐ Trigeminal neuralgia
☐ Hydrocephalus
☐ Intra-cranial bleeding
☐ Dementia
☐ Narcolepsy
☐ Parkinson's disease
☐ Other: _____
☐ Seizures
☐ Intellectual Disability
☐ Multiple sclerosis
☐ TIA/Transient Ischemic Attack
☐ Peripheral neuropathy

Genetic/Metabolic: ☐ *None of these apply*

☐ Birth defects
☐ Chromosomal disorder
☐ Congenital deformity
☐ Cystic fibrosis
☐ Down syndrome
☐ Metabolic syndrome
☐ Obesity
☐ Other: _____

Disabilities: ☐ *None of these apply*

☐ Cognitive/learning disability
☐ Hearing impairment/deficit
☐ Hemiparesis
☐ Paraplegia
☐ Quadriplegia
☐ Vision impairment/deficit
☐ Other: _____

SURGICAL HISTORY

Endocrine: ☐ *None of these apply*

☐ Parathyroidectomy
☐ Thyroid surgery
☐ Other: _____

Respiratory: ☐ *None of these apply*

☐ Bronchoscopy
☐ Lobectomy
☐ Other: _____

Cardiovascular: ☐ *None of these apply*

☐ Ablation
☐ Angiogram
☐ Angioplasty
☐ CABG/Coronary Artery Bypass Graft
☐ Cardioversion
☐ Carotid endarterectomy
☐ Congenital defect repair
☐ Coronary stent
☐ Heart transplant
☐ ICD/Implantable Cardioverter Defibrillator
☐ Pacemaker
☐ Valve replacement
☐ Venous surgery
☐ Other: _____

***Gastrointestinal:** ☐ *None of these apply*

☐ Hemorrhoidectomy ☐ Colonoscopy ☐ Endoscopy/EGD
☐ Appendectomy (appendix) ☐ Cholecystectomy (gallbladder) ☐ Exploratory laparotomy
☐ Splenectomy (spleen) ☐ Colectomy (colon resection) ☐ Hiatal Hernia repair
☐ Pancreatectomy (pancreas) ☐ Other hernia repair: _____ ☐ Paraesophageal Hernia repair
☐ Any other surgeries performed on the esophagus, stomach, duodenum, spleen or pancreas? _____

***Bariatric/Metabolic/Weight Loss:**

☐ Adjustable Gastric Banding (Lap Band) ☐ Roux-en-Y Gastric Bypass (RnYGB)
☐ Sleeve Gastrectomy (LSG, VSG) ☐ Vertical Banded Gastroplasty (VBG)
☐ Mini / Single Loop Gastric Bypass ☐ Vagal nerve blocking therapy (VBLOC)
☐ Percutaneous gastric drainage device (AspireAssist) ☐ Any gastric stapling procedure (not listed)
☐ Biliopancreatic Diversion (BPD) ☐ Single anastomosis duodeno-ileal bypass (SADI-S)
☐ Biliopancreatic Diversion with Duodenal Switch (BPD/DS)

***Endoscopic:** ☐ Endoscopic Sleeve Gastroplasty (ESG) ☐ Intragastric Balloon (Orbera)

***GERD/Reflux:** ☐ Fundoplication (Nissen, Toupet, Watson, Dor, TIF Procedure, Collis Gastroplasty)
☐ Ring (Fobi or Silastic) procedure

If you have a history of any *Gastrointestinal surgery/procedure above (*), please list below:

1st Procedure: _____ Date/year: _____ Location (City/State/Country): _____
Hospital/Facility: _____ Surgeon: _____ Reason: ☐ Wt Loss ☐ GERD ☐ Other

2nd Procedure: _____ Date/year: _____ Location (City/State/Country): _____
Hospital/Facility: _____ Surgeon: _____ Reason: ☐ Wt Loss ☐ GERD ☐ Other

3rd Procedure: _____ Date/year: _____ Location (City/State/Country): _____
Hospital/Facility: _____ Surgeon: _____ Reason: ☐ Wt Loss ☐ GERD ☐ Other

4rd Procedure: _____ Date/year: _____ Location (City/State/Country): _____
Hospital/Facility: _____ Surgeon: _____ Reason: ☐ Wt Loss ☐ GERD ☐ Other

Genitourinary: ☐ *None of these apply*

☐ Bladder surgery ☐ Kidney transplant ☐ TURP/Transurethral Resection of Prostate
☐ Bulking agent ☐ Lithotripsy ☐ Vasectomy
☐ Cystoscopy ☐ Nephrectomy ☐ Other: _____
☐ Kidney stone extraction ☐ Prostatectomy

Neurologic: ☐ *None of these apply*

☐ Craniotomy ☐ VP shunt placement ☐ Other: _____
☐ Spinal surgery ☐ VP shunt revision

Breasts: ☐ *None of these apply*

☐ Breast augmentation ☐ Breast reduction ☐ Mastectomy: _____
☐ Breast biopsy ☐ Lumpectomy ☐ Other: _____

FAMILY MEDICAL HISTORY

- ☐ Acute myocardial infarction
- ☐ Adverse reaction to anesthesia
- ☐ Alcohol abuse
- ☐ Anemia
- ☐ Asthma
- ☐ Atherosclerosis
- ☐ Autoimmune disorder
- ☐ Breast cancer
- ☐ Cerebrovascular accident
- ☐ Colon cancer
- ☐ Congenital anomaly
- ☐ Congestive heart failure
- ☐ Coronary artery disease
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes mellitus
- ☐ Drug abuse
- ☐ Eczema
- ☐ Gastric cancer
- ☐ Genetic disorder
- ☐ Hyperlipidemia/high cholesterol
- ☐ Hypertension/high blood pressure
- ☐ Kidney disease
- ☐ Learning disability
- ☐ Liver disease
- ☐ Lung cancer
- ☐ Malignant hyperthermia
- ☐ Malignant neoplasm of kidney
- ☐ Malignant neoplasm of uterus
- ☐ Other: _____
- ☐ Mental disorder
- ☐ Obesity
- ☐ Other blood disorders
- ☐ Ovarian cancer
- ☐ Pancreatic cancer
- ☐ Prostate cancer
- ☐ Rheumatoid arthritis
- ☐ Seizures
- ☐ Skin cancer
- ☐ Thyroid disease
- ☐ Tobacco abuse
- ☐ Tuberculosis
- ☐ No history available
- ☐ None of these apply

WEIGHT HISTORY

What is your current weight and height? Weight: _____ lbs. Height _____ feet _____ inches

What was your lowest adult weight? _____ lbs. Your highest adult weight? _____ lbs.

Has your weight changed in the last year? ☐ Yes ☐ No If yes, I ☐ gained or ☐ lost _____ lbs.

What do you think is a realistic weight for you? _____ lbs. Weight goal: _____ lbs.

Onset of obesity: ☐ Childhood ☐ Adolescence ☐ Adulthood

Life events related to weight gain:

- ☐ Medication induced weight gain
- ☐ Menopause
- ☐ Sleep issues
- ☐ Household issues
- ☐ Post-partum weight retention
- ☐ Smoking cessation
- ☐ Work issues (travel, schedule)
- ☐ Other: _____

DIET HISTORY

Diet Name/Medication	Year	Length of Time	MD Supervised?	Pounds Lost	Weight Regained

Are you in the process of completing physician-supervised weight loss required by your insurance company?

☐ Yes ☐ No

If yes, how many months have you completed? _____ What is the time span of the program? _____

WEIGHT COUNSELING

Have you received past diet education, counseling or coaching? ☐ Yes ☐ No

When: _____ Where: _____

Provided by: ☐ Registered Dietitian/Licensed Nutritionist ☐ Health/Wellness Coach

☐ Healthcare provider (Dr., Nurse, etc.) ☐ Other: _____

Please describe the education, counseling or coaching you received: _____

_____

List any other kinds of diets or strategies you have used to lose weight: _____

_____

PHYSICAL ACTIVITY

Have you tried exercise to lose weight? ☐ Yes ☐ No

Do you exercise daily? ☐ Yes ☐ No

Work-related activity (if applicable): ☐ Sedentary ☐ Moderate ☐ Heavy

Time spent in sedentary activities (computer, TV, etc.) per day:
☐ More than 1 hour ☐ More than 3 hours ☐ More than 5 hours ☐ Other: _____

Time spent in planned exercise:
Type of exercise: _____, _____ minutes, _____days per week
Type of exercise: _____, _____ minutes, _____days per week
Type of exercise: _____, _____ minutes, _____days per week

What other kinds of physical activity do you have during the day that is not structured exercise?

_____

What barriers do you have that prevent you from exercise? Are there any reasons why you cannot or should not exercise? _____

_____

DIET, EATING PATTERNS AND HABITS

Do you follow a special diet for any medical condition? ☐ Yes ☐ No

If yes, please describe: _____

Current diet (Regular, Vegetarian, Gluten free, Diabetic, etc.): _____

Who prepares meals in your home? _____

Do you currently have any of the following?

☐ Food allergies Please specify: _____

☐ Food or beverage intolerance Please specify: _____

☐ Food avoided for other reasons (religious/cultural/aversion) Please specify: _____

_____

☐ Chewing problems ☐ Swallowing problems ☐ Other: _____

If you eat at restaurants or fast food locations, please list the places you typically go:_____

_____

What is your typical rate of eating?	☐ Slow	☐ Medium	☐ Fast
How do you feel after most meals?	☐ Comfortable	☐ Stuffed	☐ Could eat more
Do you ever skip meals?	☐ Sometimes	☐ Often	☐ Never
Unplanned snacking?	☐ Sometimes	☐ Often	☐ Never
If so, what time of day? _____			
Do you ever wake during the night to eat?	☐ Sometimes	☐ Often	☐ Never
Do you eat when you are bored?	☐ Sometimes	☐ Often	☐ Never
Do you eat when you are angry or sad?	☐ Sometimes	☐ Often	☐ Never
Do you ever feel out of control when eating?	☐ Sometimes	☐ Often	☐ Never

DIET, EATING PATTERNS AND HABITS

Do you use any meal replacement or supplement products? ☐ Yes ☐ No

If yes, list the types, brands, and how often you take them:

Name of supplement(s): _____ ☐ Drink ☐ Bar ☐ Powder ☐ Formula

How often? ☐ Occasional ☐ Once/day ☐ Twice/day ☐ Three Times/day ☐ Other: _____

Name of supplement(s): _____ ☐ Drink ☐ Bar ☐ Powder ☐ Formula

How often? ☐ Occasional ☐ Once/day ☐ Twice/day ☐ Three Times/day ☐ Other: _____

Name of supplement(s): _____ ☐ Drink ☐ Bar ☐ Powder ☐ Formula

How often? ☐ Occasional ☐ Once/day ☐ Twice/day ☐ Three Times/day ☐ Other: _____

How often do you drink the following beverages? List the amounts you typically drink in a day (1 cup, 1 can, etc.).
Example: Coffee (black): *1-2 cups/day*

Coffee (black): _____ Coffee additions (creamer, sugar, etc.): _____

Specialty coffee/tea (lattes, cappuccino, etc.): Unflavored: _____ Flavored: _____

Tea (unsweetened): _____ Sweet tea (Snapple®, etc.): _____ Diet teas: _____

Water: _____ Sparkling water: _____ Sugar-free flavoring (Crystal Light®, etc.): _____

100% fruit juice or fruit/vegetable juice blends: _____ Smoothies: _____

Regular soda: _____ Diet soda: _____ Punch or lemonade: _____

Sports drinks (Gatorade®, Powerade®, etc.): _____ Diet sports drinks (G2®, etc.): _____

Energy drinks (Red Bull®, Monster®, etc.): _____ Diet energy drinks: _____

Milk: Whole: _____ 2%: _____ 1%: _____ Nonfat/skim: _____ Chocolate: _____

Milk Alternative: Soymilk: _____ Almond milk: _____ Rice milk: _____ Lactaid: _____

Other beverages: _____

DAILY SCHEDULE

Occupation: _____ ☐ Full Time ☐ Part Time ☐ Retired ☐ Other: _____

Work Schedule/Hours: Monday: _____ Tuesday: _____ Wednesday: _____

Thursday: _____ Friday: _____ Saturday: _____ Sunday: _____

Weekday/Workday Meal and Snack Routine:

Meal times: 1st meal_____ AM / PM 2nd meal_____ AM / PM 3rd meal_____ AM / PM

Snack times: _____ AM / PM _____ AM / PM _____ AM / PM _____ AM / PM

How many meals do you eat away from home on weekdays? Breakfasts: _____ Lunches: _____ Dinners: _____

Weekend/Off Day Meal and Snack Routine:

Meal times: 1st meal _____ AM / PM 2nd meal _____ AM / PM 3rd meal _____ AM / PM

Snack times: _____ AM / PM _____ AM / PM _____ AM / PM _____ AM / PM

How many meals do you eat away from home on weekends? Breakfasts: _____ Lunches: _____ Dinners: _____

Weekday/Workday Sleep Schedule: Normal wake time: _____ AM / PM Normal bedtime: _____ AM / PM

Weekend/Off Day Sleep Schedule: Normal wake time: _____ AM / PM Normal bedtime: _____ AM / PM

SUPPORT SYSTEM, MOTIVATION & LEARNING STYLE

Spouse/Significant other name: _____ Relationship: _____

Support person(s) who will be involved in your care: _____

Please rate your current level of motivation to change your lifestyle and eating behaviors:

Rating scale: 1= Very Unmotivated 10= Very motivated

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Primary language spoken: ☐ English ☐ Other: _____

Learning preferences: (mark all that apply):

☐ Written Instructions ☐ Verbal Instructions ☐ Visual Demonstration ☐ Hands-on Learning

Do you have any customs or cultural factors that influence eating behaviors? ☐ Yes ☐ No

If yes, please explain: _____

Are there any barriers or challenges to learning that we should know about? ☐ Yes ☐ No

If yes, please explain: _____

3 DAY FOOD DIARY (continued on pg. 10)

Instructions:

Write down everything you eat & drink for 3 days, including food or beverage description, time, & quantity.

Note: Please include *at least one week day and one weekend day.*

Example: Day 1 Date: 7/7/16 Thursday

Meal #1 **Time:** 8:00am		**Meal #2** **Time:** 12:30pm		**Meal #3** **Time:** 6:30pm	
Food/Beverage	**Amount**	**Food/Beverage**	**Amount**	**Food/Beverage**	**Amount**
1% Milk	8oz	Apple	Medium	Ravioli w/ meat sauce	2 cups
Oatmeal, plain	1 cup	12" Turkey sandwich from Subway w/ light mayo & lettuce	1	Brownie	2 inch square

DAY 1 Date: **Choose any weekday:** ☐ M ☐ T ☐ W ☐ Th ☐ F

Meal #1 **Time:**		**Meal #2** **Time:**		**Meal #3** **Time:**	
Food/Beverage	Amount	Food/Beverage	Amount	Food/Beverage	Amount
Snack #1 Time:		Snack #2 Time:		Snack #3 Time:	
Food/Beverage	Amount	Food/Beverage	Amount	Food/Beverage	Amount

Additional notes about day 1: _____

DAY 2 Date: **Choose any weekend day:** ☐ Saturday ☐ Sunday

Meal #1 Time:		**Meal #2 Time:**		**Meal #3 Time:**	
Food/Beverage	Amount	Food/Beverage	Amount	Food/Beverage	Amount
Snack #1 Time:		**Snack #2 Time:**		**Snack #3 Time:**	
Food/Beverage	Amount	Food/Beverage	Amount	Food/Beverage	Amount

Additional notes about day 2: _____

_____

DAY 3 Date: **Choose any type of day:** ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ Sa ☐ Su

Meal #1 Time:		**Meal #2 Time:**		**Meal #3 Time:**	
Food/Beverage	Amount	Food/Beverage	Amount	Food/Beverage	Amount
Snack #1 Time:		**Snack #2 Time:**		**Snack #3 Time:**	
Food/Beverage	Amount	Food/Beverage	Amount	Food/Beverage	Amount

Additional notes about day 3: _____

_____

Is there anything else that you'd like the dietitian to know? _____

_____

_____