The Baton Rouge Clinic Surgery Department
Nutritional Information Sheet

Date: Patient Name: Act#

Directions: For each question, please check a box in the "Weekly Consumption" column.

	WEEKLY CONSUMPTION		
	Rarely/Never	*3 or less times/wk*	*4 or more times/wk*
1. Are your meals planned?	☐	☐	☐
2. How often do you eat fast food? Ex: McDonalds, Sonic, Taco Bell	☐	☐	☐
3. How often do you have fried food? Ex: french fries, fried chicken, shrimp	☐	☐	☐
4. How often do you have convenience foods? Ex: canned, packaged, or frozen dinners	☐	☐	☐
5. How often do you eat a home prepared meal?	☐	☐	☐
6. How often do you have high calorie drinks? Ex: milkshakes	☐	☐	☐

Please answer the following questions:

1. How many meals a day do you typically have?
2. How many snacks do you eat per day?
3. How many non-diet soft drinks do you have a day?
4. Are there any foods, snacks, beverages you could not live without? If so, please list:

The Information provided in this form is true and complete to the best of my knowledge.

Patient Signature:

Form reviewed by Physician: Date:

Last Revised: 08/01/2025