Hunterdon Health
Center for Nutrition & Diabetes Management
Wescott Medical Arts Building
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Phone: 908-237-6920 | www.hunterdonhealth.org

Weight Loss Surgery Nutrition Assessment

Please fill out all of the information on this form and bring it to your nutrition appointment.
(Please use a pen. Do not use pencil.)

Name:_____Date of Birth:_____Today's Date: _____

Referring Physician:_____ Bariatric Physician: _____

Type of Surgery: Gastric Bypass Adjustable Gastric Banding Vertical Sleeve Gastrectomy

Pending date of surgery:_____ Number of visits needed:_____

Height: _____ **Current Weight**: _____ Desired Goal Weight: _____

Usual Body Weight: _____ Highest Weight: _____

Childhood Weight: (circle) Underweight Average Overweight

History of Anorexia/Bulemia: Yes No

Do you have a tendency to: Binge eat Eat when stressed Eat when upset/sad
Eat late at night Graze

Brief history of weight loss attempts (include names of programs, weight lost/gained):

_____

_____

_____

Medical History: (please circle those that apply)

Sleep Apnea Diabetes Pre-Diabetes High Cholesterol High Blood Pressure
Heart Disease PCOS Other:_____
Arthritis

Please list food allergies and/or drug allergies: _____

_____

_____

Please list nutritionally pertinent medications and supplements: _____

_____

_____

Are you presently exercising? ☐ Yes ☐ No If yes, what is your regimen?_____

Reasons for not exercising:_____

Have you recently felt down, depressed, hopeless or have little or no interest/pleasure in doing things? ☐ Yes ☐ No

Are you being treated for depression? ☐ Yes ☐ No

Learning Style:

Have you had previous diabetes or nutrition education? ☐ Yes ☐ No
If yes, where? _____and how long ago?_____

The most important things I want to learn today are:

1. _____
2. _____
3. _____

Intake History:

Do you drink alcohol? ☐ Yes ☐ No If so, how much? _____

Do you smoke? ☐ Yes ☐ No If so, how much? _____
Do you have any religious or cultural observations that affect how you eat?

☐ Yes ☐ No If yes, please explain _____
Who prepares your meals?_____

How are your meals usually prepared? ☐ Fried ☐ Baked ☐ Grilled ☐ Broiled ☐ Other _____
How many times a week do you eat away from home?_____a week.

☐ Fast Food ☐ Restaurant ☐ Take Out ☐ Other_____

Do you: ☐ Skip meals ☐ Nibble between meals ☐ Eat rapidly ☐ Have food cravings

☐ Use convenience foods ☐ Eat unplanned meals ☐ Other_____

Based on one day:
How much milk or yogurt do you consume in one day? _____
How many vegetables?_____
How many fruits? _____
How much water do you drink in one day? _____
What are your main beverages? _____
Please list any trigger foods that may make you overindulge:_____

Name: _____Date: _____

Please record your food intake. What kind of food? How much food?

BREAKFAST **TIME:_____**	**MORNING SNACK** **TIME:_____**
LUNCH **TIME:_____**	**AFTERNOON SNACK** **TIME:_____**
DINNER **TIME:_____**	**EVENING SNACK** **TIME:_____**

_____RD DATE: _____

Notes/Comments: _____

_____

_____

Office Use Only Please _____

_____

Educational Materials Provided: _____