Hunterdon Health
Center for Nutrition & Diabetes Management
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Weight Loss Surgery Nutrition Assessment

PLEASE USE PEN. DO NOT USE PENCIL.

Please fill out all of the information on this form and bring it to your nutrition appointment.

Name: ___________________________ **Date of Birth:** _______________ **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: ☐ 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)

Diabetes Heart Disease Pre-Diabetes High Cholesterol High Blood Pressure

Arthritis Sleep Apnea Polycystic Ovarian Syndrome (PCOS) Other _________________

Please list food allergies and/or drug allergies: ____

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Please list nutritionally pertinent medications and supplements: _________________________

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____

Exercise:

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

Reasons for not exercising? ____

CNDMForms2025:WeightLossSurgeryNutritionSelfAssessment1/16/2025

Depression:

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 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 ☐ Broiled ☐ Grilled ☐ 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 servings do you consume? ____________________________________

How many vegetable servings? _______________ How many fruit servings? ____________

How much water do you drink? ____

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:____

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Educational Materials Provided: ____