

Bariatric Initial Nutrition Assessment
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NAME: _____ DATE: _____

DOB: ____/____/____ AGE: _____

SURGEON: _____ SURGERY TYPE: _____

CURRENT WEIGHT: _____ HEIGHT: _____

LOWEST ADULT WEIGHT: _____ HIGHEST ADULT WEIGHT: _____

MOST USUAL ADULT WEIGHT: _____

DESIRED GOAL WEIGHT: _____

CHILDHOOD WEIGHT (circle one): UNDER AVERAGE OVER

CONTRIBUTING FACTORS TO OBESITY:

Medical History

- | | |
|---|--|
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> ARTHRITIS |
| <input type="checkbox"/> HYPERTENSION | <input type="checkbox"/> HIGH CHOLESTEROL |
| <input type="checkbox"/> SLEEP APNEA | <input type="checkbox"/> LIVER/RENAL DISEASE |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> GALLBLADDER DISEASE |
| <input type="checkbox"/> GI PROBLEMS | <input type="checkbox"/> GERD |
| <input type="checkbox"/> CARDIOVASCULAR DISEASE | <input type="checkbox"/> OTHER: _____ |

IS THERE FAMILY HISTORY OF OBESITY OR ANY OF THE ABOVE CONDITIONS? PLEASE SPECIFY:

HISTORY OF ANOREXIA/BULIMIA/BINGE EATING?

PLEASE LIST ANY FOOD ALLERGIES:

DO YOU HAVE ANY DIET RESTRICTIONS?

MEDICATIONS/SUPPLEMENTS:

ARE YOU CURRENTLY EXERCISING? IF YES, WHAT IS YOUR REGIMEN?

HOW MANY TIMES PER WEEK DO YOU EAT OUTSIDE THE HOME? _____

HOW OFTEN DO YOU EAT THE FOLLOWING FOODS IN A WEEK?

○ SWEETS (COOKIES, CANDY, ETC) _____ ○ LIQUID SWEETS (SODA, JUICE, ETC) _____
○ FRIED FOODS _____ ○ SALTY SNACKS _____ ○ FAST FOODS _____

WHICH OF THE FOLLOWING BEVERAGES DO YOU DRINK?

○ COFFEE ○ TEA ○ SODA ○ DIET SODA ○ WATER ○ JUICE ○ MILK ○ OTHER _____

DO YOU CONSUME ALCOHOL? _____

IF YES, HOW OFTEN AND WHICH TYPE? _____

DO YOU EAT FRUITS/VEGETABLES EVERYDAY? _____

IF YES, PLEASE SPECIFY TYPE & HOW MANY SERVINGS DAILY: _____

DO YOU CONSUME DAIRY PRODUCTS DAILY? _____

IF YES, HOW OFTEN AND WHICH TYPE? _____

DO YOU EAT RED MEAT/CHICKEN/TURKEY/FISH/TOFU/BEANS/EGGS/NUTS? (circle answer(s))

DO YOU EAT AT LEAST 1 OF THESE DAILY? _____

WHICH IS YOUR FAVORITE? _____

DO YOU ADD BUTTER/MARGARINE/SALAD DRESSING/OIL/MAYONNAISE TO YOUR FOOD? If yes, please circle answer(s).

WHAT IS A TYPICAL BREAKFAST?

WHAT IS A TYPICAL LUNCH?

WHAT IS A TYPICAL DINNER?

WHAT DO YOU LIKE TO SNACK ON?

PAST METHODS/ATTEMPTS TO LOSE WEIGHT, PRIOR TO CONSIDERING SURGERY (i.e. WEIGHT WATCHERS, ATKINS, MEDICATIONS, EXERCISE, ETC):

TYPE	DATES	WEIGHT CHANGE

