

Bariatric Surgery Nutrition Assessment  
NYU Medical Center  
Barrie Wolfe MS, RD

Name \_\_\_\_\_ Date \_\_\_\_\_ Age \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Desired Goal Weight \_\_\_\_\_  
Highest weight & when \_\_\_\_\_ Lowest weight & when \_\_\_\_\_  
History of Binge Eating? \_\_\_\_\_ History Anorexia/Bulimia? \_\_\_\_\_  
Regular menses (if applicable)? \_\_\_\_\_

**Please circle below medical conditions if applicable:**

Sleep apnea      Diabetes      High Cholesterol      Hypertension  
Difficulty Breathing      Arthritis      Heart Disease      Other \_\_\_\_\_

Please note if there is a family history for obesity *and/or* any of the above chronic diseases.

Are you presently exercising? If so, what is your regimen?

Please list any food allergies and/or intolerances.

Please list your medications, vitamins, minerals, herbs etc.

Please list some of the diet programs you have tried (i.e. Weight Watchers, nutritionist, calories counting).

**Diet Information** *Answer as best you can. This information provides the nutritionist with information on your daily food intake.*

How many times per week do you eat fast food? \_\_\_\_\_

How many times per week do you dine out? \_\_\_\_\_

How many times per week do you eat fried foods? \_\_\_\_\_

How many times per week do you eat sweets (cookies, cake, ice cream, chocolate, etc)? \_\_\_\_\_

How many times per week do you consume alcohol? \_\_\_\_\_

Circle the beverages you drink – juice    soda    snapple    milk    fruit drinks  
water    other \_\_\_\_\_

Do you add butter, margarine, salad dressing oil, mayonnaise, etc. to your food? \_\_\_\_\_

Do you eat fruits and vegetable every day? \_\_\_\_\_

Do you eat cheese and/ or yogurt every day? \_\_\_\_\_

Circle the protein rich foods you enjoy most-

Red meat   chicken   tofu   eggs   nuts   lamb   fish   turkey

What do you perceive as your biggest weakness in your diet?

(i.e. Portion control, late night eating, grazing, emotional eating, etc.)

**(FOR DIETICIAN'S USE ONLY)**

**24 hour recall**

Breakfast

Lunch

Dinner

Snacks

**BMI** \_\_\_\_\_    **IBW** \_\_\_\_\_    **%IBW** \_\_\_\_\_    **Goal weight** \_\_\_\_\_

**Estimated Kcal:** \_\_\_\_\_    **Protein** \_\_\_\_\_    **%CHO** \_\_\_\_\_    **%Fat** \_\_\_\_\_  
**%Pro** \_\_\_\_\_

**Surgery Type:**    **Lap Band**    **Gastric Bypass**    **BPD**

**Assessment:**

**Pt was educated on the appropriate diet?**    **YES**    **NO**

**Pt will follow up with RD?**    **YES**    **NO**