



**Center for
Nutrition & Diabetes
Management**

HUNTERDON HEALTHCARE SYSTEM
The Heart of Modern Medicine

WESCOTT MEDICAL ARTS CENTER
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Weight Loss Surgery Nutrition Assessment

Name: _____ Date: _____ Age: _____

Surgeon: Dr. _____ Type of Surgery: (Circle) GB BPD-DS Lap Band
Medical center where surgery was performed (if applicable) _____

Height: _____ Weight: _____ Desired Goal Weight: _____
Weight lost since surgery (if applicable) _____

Childhood Weight: (Circle) Underweight Average Overweight

Reasons for Obesity: _____

History of Binge Eating _____ History of Anorexia/ Bulemia _____

Weight Loss Program	Dates	How long on plan?	How much lost?	Doctor supervised?
"Weight Watchers"				
"Nutrisystem"				
"Jenny Craig"				
"Atkins"				
"Optifast/Medifast"				
Hospital Based				
Prescription Meds				
Exercise Programs				
Health Spas				
Nutritionists				
Others				

Medical History (please check all that apply)

Sleep Apnea Diabetes High Cholesterol Hypertension
Arthritis Heart Disease PCOS Other _____

Is there a family history of obesity or any of the above ? If so, please specify.

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

Please list Food Allergies and/or Drug Allergies:

Please list medications and supplements:

Do you drink alcohol? _____ If so, how much? _____