



Lutheran Medical Center
Surgical Weight Loss Institute.

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Nutrition Assessment

Staten Island

Brooklyn

Name (please print) _____ Date _____

Gender Male Female

Telephone number (s) _____

Address _____

Email address _____

Date of birth _____ Age _____ Height _____

Current weight _____ How long have you been overweight? _____

Lowest weight _____ When(year) / Comments _____

Highest weight _____ When(year) / Comments _____

What is your goal weight? _____

What type of procedure are you considering?

Lap-Band

Gastric Bypass (Roux-en-Y)

Briefly describe why you have chosen to have this procedure: _____

Do you know anyone that had Bariatric surgery? Yes No

How do you know them? _____

How were you referred to this office? _____

To be completed by Nutritionist ONLY

DBW _____

% DBW _____

BMI _____

Initial MD visit _____

Insurance _____

Ht in cm _____

MEDICAL HISTORY

Are there any personal struggles in your life (physical or emotional), that are associated with physical limitations you experience due to your weight status? If so, briefly describe:

How frequent are these symptoms?

- Daily
- Weekly
- Monthly

How severe are they?

- Interfere with daily living
- Difficult to tolerate
- Somewhat bothersome

Do you have a history of any eating disorder, such as anorexia or bulimia? If so, when and did you seek help?

Do you have any of the following medical conditions?, please circle:

High blood pressure

High blood cholesterol

Diabetes

Asthma

Sleep Apnea

Emphysema

Arthritis

Heart disease

Heartburn

Other: _____

What medications do you take, for the above conditions or anything else (list both prescriptions and over the counter):

Do you have any allergy to medications? YES NO

If so, please list: _____

Do you have any family history of any of the above-mentioned medical conditions? If so, which conditions?

Do you have a family history of obesity? YES NO

Have you ever had surgery? YES NO

If so, please list type and year: _____

FOR WOMEN: Do you have any menstrual irregularities, fibroids or ovarian cysts? _____

DIET INFORMATION

Please list any vitamins, minerals or herbal supplements you are currently taking: _____

Please list some of the diet programs or diet products you have tried, length of time followed and how much weight you lost?

How many times per week you eat out, get take-out and/or eat "fast food", and please list some examples of places and types of foods you choose:

How often do you eat the following foods:

	Daily	Weekly	Seldom	Never
Sweets (such as, ice cream, candy, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fried and/or high fat foods (such as chips, KFC, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Butter, margarine, oil, mayo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fresh fruits/vegetables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dairy products (such as, milk, cheese, yogurt)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list some examples of any sweets or fried/high fat foods you indulge in: _____

Do you snack? If so, please list when, what, and how much: _____

DIET INFORMATION

Do you drink water each day? YES NO
If yes, how much / If not, why? _____

List other beverages you drink during the day: _____

Do you drink alcoholic beverages?, circle the appropriate answer (s)
Daily Weekends Occasionally Seldom Never

Do you smoke cigarettes? If so, how many? NO YES, _____

Does emotional issues trigger eating? NO YES
If so , please describe _____

Is there anything else you would like to share: _____

Briefly explain the reasons why you are considering Bariatric surgery:

THANK YOU.