

CORNELL WEIGHT LOSS SURGERY PROGRAM NUTRITION ASSESSMENT

Name: _____ Date: _____ Age _____

Surgeon: _____ (Please Circle:) Gastric Bypass / BPD-DS / Band / Sleeve Gastr'y

Height: _____ Weight: _____ Desired Goal Weight _____

Heaviest Weight and When _____ Lowest Weight (Since 21) _____

Childhood Weight (circle): Under Average Over

Reasons for Obesity _____

History of Anorexia/Bulimia _____ History Of Binge Eating _____

Weight Loss Program	Dates	How long on this?	How much lost?	MD/RD Supervised?
"WeightWatchers"				
"Nutrisystem"				
"Jenny Craig"				
"Atkins"				
"Optifast" / "Medifast"				
Hospital Based Programs / Spas				
Prescription Meds				
Exercise Programs				
"Slimfast" / shakes				
Nutritionists				
Others				

Please check off appropriate box:

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

Is there a family history of obesity or any of the above chronic diseases? If so, which ones? _____

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

Please list food allergies and/or intolerances: _____

Please list medications / Vitamins / Minerals / Supplements / Herbs: _____

(goto next page →)

Name _____

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How many times per week do you eat fast foods? _____

How many times per week do you dine out? _____

How many times per week do you eat fried food? _____

Do you add butter, margarine, salad dressing, oil, or mayonnaise to your food? (please circle)

How often do you eat sweets (cookies, cakes, candy, ice cream, chocolate)? _____ times / week

Which of the following beverages do you drink? water diet drinks
 juice regular soda fruit drinks milk coffee tea iced tea

How often do you consume alcohol? _____ Which type(s)? _____

Do you feel you crave the following foods:

rice pasta bread cereal potatoes

Do you eat fruits and vegetables every day? Yes No

Do you eat cheese or yogurt everyday? Yes No

Do you eat red meat, chicken, turkey, fish, tofu, beans, eggs OR nuts (please circle which you eat)

Do you eat at least one of these every day? Yes No Which is your favorite? _____

What ("nutrient") do these foods have in common? _____

What is the first thing that you eat or drink each day?

What is a typical Lunch?

What is a typical Dinner?

What do you like to snack on?