Bariatric Surgery Nutrition Screening Form

Patient Name

Date of Birth

Date

Height (cm)

Weight (kg)

BMI

Medical History

List relevant medical conditions

Diabetes

Hypertension

Sleep Apnea

Other

Weight History

Previous weight loss attempts

Recent weight changes

Nutrition Assessment

Describe typical daily food and beverage intake

Vitamins/minerals/supplements

Behavioral Assessment

Eating behaviors/concerns

Smoking

Alcohol Intake

Physical Activity

Allergies/Food Intolerances

List allergies or intolerances