Patient Name: _____ **Date:** _____

SURGERY: Post-Operative Visit Data Sheet

Date of Surgery_____

Type Please Circle: Lap Gastric Bypass LapBand Sleeve Balloon Hiatal Hernia other

Which are you taking daily please circle:

Fusion - # per day____ Multivitamin name:_____ B-Complex B12 Calcium Citrate Vitamin D

Please circle your answers:

How is your appetite compared to before surgery?	Same Less More
Does food tend to get stuck? If so, how often?	Y N - All the time Frequently Infrequently
Does food get stuck when eating too fast?	Y N
Do you have pain when eating? If so, how often?	Y N - All the time Frequently Infrequently
Are you presently experiencing any nausea?	Y N
Are you having any reflux, GERD or heartburn? If so, how often?	Y N - All the time Frequently Infrequently
Are you vomiting? If so, circle all that apply.	Y N - Blood Coffee colored Mucus Bile
Are you presently having diarrhea? If so, is it bloody or black/tarry?	Y N - Bloody Black/Tarry
Are you presently constipated?	Y N
When you eat chicken breast or other solid protein, how much can you eat until feeling full?	1/4 1/2 All
How many times a day are you eating, including snacks?	1-2 2-3 3-4 4-5 5-6 6+
How much <u>solid</u> food can you eat at a time?	1/2 cup 1 cup 1-1/2 cup more_____
How many ounces of fluid (including protein drinks, tea, water, etc.) do you drink in a day?	Less than 32 oz 32-48 48-64 64 +
How are your clothes fitting?	Looser Same Tighter
Are you presently experiencing more hair loss than prior to surgery?	Y N
Are you presently separating your foods and fluids by 30 minutes?	Y N

Medical Information:

1. Have you had any changes to any of your other medications, or addition of any new medications (ex: for blood pressure, diabetes, etc)? YES or NO. If YES, please list name of medication, change of medication, and prescribing provider: _____Please address on Medication sheet given to you_____
2. Have you had any labs or other testing since your last appointment? If YES, when and with which provider?
   _____
3. Are you having any side effects from your treatment plan? If so, please list:
   _____
4. Do you monitor your blood pressure at home? If so, what are your home readings? _____
5. Do you monitor your blood glucose at home? If so, what are your home readings? _____

Patient Name: _____ Date: _____

Weight-Loss Medication (skip this section if you are not taking a weight-loss medication)

6. Which prescription weight loss medication are you taking and which dose are you taking? If not on a medication, write N/A_____
7. Do you need a refill on your weight loss medication? YES or NO
8. Did you experience any side effects from your weight loss medication? YES or NO. If YES, please list your side effects: _____

Sleep and Stress

1. Average number of hours of sleep:_____ CPAP Used? YES NO N/A
2. How would you rate the quality of your sleep? (circle): GOOD MODERATE POOR
3. On a scale of 1 to 10, how would you rate your stress levels in the past month? _____
4. Have you experienced any new stressors since your last visit?

_____

Nutrition

1. How many days in the past week did you track your nutrition with an app or journal? _____
   Average calories per day: _____
   Average grams of carbs: _____
   Average grams of protein:_____
2. Deviations from your nutrition plan:_____

Typical Diet: Please Describe your most common eating and drinking habits for each category.

Meal/ Snack	Time of Day	Typical foods eaten/ beverages drank and who prepared food (ex: self, spouse, restaurant, cafeteria, fast food, etc)
Breakfast		
Morning snack		
Lunch		
Afternoon snack		
Dinner		
Evening snack		
Late night snack		
Grazing		

1. Do you have any barriers when it comes to eating choices (financial, time, cooking skills, etc)? YES or NO. If "YES", please elaborate: _____

Physical Activity

1. How many days a week did you exercise this week?_____
2. How many minutes was each bout of exercise? _____
3. What type of exercise and intensity: Mild/ Moderate/ High intensity: _____
4. Are you experiencing any barriers to physical activity? _____

Patient Name: _____ Date: _____

Please check if you are experiencing any of the following symptoms:

General:
___ Fatigue or loss of energy
___ Difficulty sleeping

Eyes:
___ Blurred vision
___ Double vision

Ears, Nose & Throat:
___ Chronic headaches
___ Dizziness
___ Chronic nasal congestion
___ Nose bleeds
___ Recurrent sinus infections
___ Bleeding gums
___ Sore throat

Respiratory:
___ Shortness of breath
___ Cough
___ Chest congestion
___ Wheezing
___ Coughing up blood

Sleeping:
___ Tossing & turning at night
___ Waking up coughing, choking or gasping for air
___ Chronically tired
___ Falling asleep driving, at work or school

Cardiovascular:
___ Chest pain
___ Heart flutter or racing
___ Heart Murmur
___ Leg swelling
___ Decreased exercise tolerance
___ Waking due to shortness of breath

Genitourinary:
___ Frequent urination
___ Frequent urge to urinate
___ Pain on urination
___ Bloody urine
___ Vaginal discharge

Lymphatic/Hematological:
___ Unusual lymph node swelling (neck, arm pit or groin)
___ History of anemia
___ Blood clots
___ Bruise easily
___ Unusual bleeding

Musculoskeletal:
___ Limb or joint pain
___ Muscle weakness
___ Muscle spasms or twitching
___ Recurrent back/neck pain

Neurological:
___ Seizures
___ Tremors/shakiness
___ Limb weakness
___ Numbness/tingling
___ Altered consciousness or black-outs

Skin:
___ Itching and/or rash
___ Unusual dryness
___ Changes in hair

Psychological:
___ Lapse in memory
___ Troublesome depression
___ History of mental illness

Allergy:
___ Seasonal allergies
___ Sensitivity to specific item or new medication:

If so, what?_____

Do you have any questions or problems you would like the staff to address? Please note:

_____

_____

_____