Patient Name: _____ **Date:** _____

SURGERY: 1-2 WEEK Post-Operative Visit Data Sheet

Date of Surgery_____

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

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
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 much protein are you getting in a day	less than 20g 20 to 40g 60g or more

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: _____
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? _____

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

PLEASE COMPLETE OTHER SIDE ➔➔➔

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:

_____

_____

_____

PLEASE COMPLETE OTHER SIDE ➔➔➔