Band Surgery Follow-up Sheet

Are you able to swallow thin liquids easily?..yes/no
How many glasses of water or other hydrating fluids do you drink each day? __________
How many times per day do you eat protein? (Remember we do not insist that you eat on a schedule)______________________________
What are the 3 foods you eat most frequently? ______________________________
Are you taking a multivitamin & mineral supplement each day? ....yes/no
Are you taking a 60mg Iron tablet (ferrous fumarate) each day.........................yes/no
Are you taking a Calcium Citrate with Vitamin D3 each day? ....yes/no
Are you taking 5000IU Vitamin D3 each day?...yes/no
Are you taking a B12 Supplement under your tongue once each day? ....yes/no
Are you taking a B-complex Supplement that contains 50mg thiamine each day?....yes/no
Are you taking extra fiber twice each day? ....yes/no

HISTORY

Diet History	**Yes**	**No**
Tolerating meats/solid foods?		
Experiencing hunger? How often? ______		
Eating sweets?		
Sodas? How often? ______		
Portion sizes (compare to before surgery meals) (circle) 25% 50% 75% 100%	X	X
How many hours after a meal are you hungry?(circle) 1-2 hrs 3-4 hrs 5-6 hrs Never	X	X
Do you eat soft, mushy foods because you are afraid to eat solid foods?		
Do you drink liquids with meals?		
Would you do weight loss surgery again?		
Symptoms	**Yes**	**No**
Nausea		
Vomiting		
Difficulty Swallowing		
Heartburn or reflux		
Regurgitation		
Night Cough		
Poor Eating Behavior		
Problems with bowel movements or function?		
Pain that concerns you? Describe:		
Fever?		
Breathing problems?		

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Possibility that you are pregnant or planning to become pregnant?		
Social History	**Yes**	**No**
Do you drink alcohol? Amount per week?		
Do you smoke? Amount per day?		
Do you use street drugs?		
Do you exercise?		
Times per week? 1 2 3 4 5 6 7		
Do you attend support group?		
Quality of Life, Current Rating: (circle one) *Very Satisfied, Satisfied, Somewhat Satisfied, Neutral, Somewhat Dissatisfied, Dissatisfied, Very Dissatisfied*		

Please list any updates or changes from last visit all the medications you are taking prescription or over the counter to include supplements.______________________________

____

____

Rate your band today using the "Realize Fit" guide: (circle the fit)

Light fit ***Right fit*** ***Tight Fit***

____

Patient Signature/ Date

\-

(office use only)

Adjustable Gastric Band follow up assessment was reviewed and verified with patient:

RN Signature:____________________________________ **Date/ Time:**________________

Comments:____

____

Health for Life Center
Patient Questionnaire - 1
(To be reviewed and updated at each patient clinic visit)

Primary language: English / Spanish / Other: ______________

Any difficulties with speech, vision or hearing? Yes / No
If yes, please list: ____

How do you learn best? (circle all that apply):
Visual instruction Verbal Instruction Demonstration
Written instruction No Preference

Do you have any learning needs regarding your health? Yes / No
Please list: ____

Are you Immunizations up to date? Yes No Not sure

Is the anything about your religious, spiritual or cultural practices that will influence the planning of your care and education? ____________________
____

Directive to Physician? Yes No Copy provided: ____________________
Medical Power of Attorney? Yes No Copy provided: ____________________
Out-Of-Hospital DNR? Yes No Copy provided: ____________________
Mental Health Directive? Yes No Copy provided: ____________________
I would like more information regarding the above advance directive information:
Yes / No If yes, please list: ____________________
Have you received a patient rights handbook in admitting? ____________________

Respiratory Screen:

Persistent cough > 3 weeks	yes	no
Travel out of the country in the last 3 months	yes	no
Night Sweats	yes	no

(Office use: One or more MD referral, notified: __________)

Functional Screen:

Decrease mobility in past 3 months	yes	no
Recent fall	yes	no
Uses walker, cane, crutches or wheelchair	yes	no
Limitations to hearing or vision	yes	no

(Office use: One or more implement standard precautions for falls, done by : _______)

Abuse Screening:

Are you in a relationship with someone who physically hurts or threatens you?	yes	no
Do you need access to a shelter / counseling	yes	no

Any changes in your medical or surgical history since last visit (to include any hospitalizations)? N/A for new patients ____________________
____

Health for Life Center
Patient Questionnaire – 2
(To be reviewed and updated at each patient clinic visit)

Bariatric Support Screening (circle all that apply):
Difficulty with stress management
Body Image Issues
Weight gain since last visit
Decrease sexual desire
Conflict or changes in relationships
Increased sadness or depression
Difficulty with sleep
Uncomfortable with attention from others
Emotional / Stress / Boredom Eating
Other: ________________________
None
(office use only - 3 or more potential referral: _____yes _____ no _____n/a)

Nutritional Screening (circle all that apply):
Feel weak and washed out
Nausea ongoing > 3days
Diarrhea ongoing > 3 days
Vomiting ongoing > 3 days
Constipation ongoing > 3 days
Not taking vitamins and / or supplements
Eating on a schedule versus when I am physically hungry
Worried about my weight loss: Too much / Too little / No weight loss over 4 weeks
None
(office use only - referral: ____yes _____no _____n/a)

- -

(Office use only)
Referrals: *__BC* *__NS* *__MD* *Other: __________*

Educational handouts, teaching and/or content reviewed:

Initial Evaluation Process	Standard Fall Precautions	Micronutrient Regime
Post-Band Adjustment Diet	Wound Care	Dehydration Prevention
Medication	Diet Compliance	Other

Comments: ____

____

Patient response to education:

Motivated	Asked appropriate questions	Verbalized understanding
Receptive	Demonstrated understanding	Repeat back instructions
Non-motivated	Needs reinforcement	Other

Comments: ____

____

RN review and signature: ____________________________ ***Date/Time:*** ____________

Methodist Healthcare
Health
for Life Center
A Department of Methodist Hospital
Your Trusted Source for Weight Loss Surgery
www.HealthforLifeCenter.com

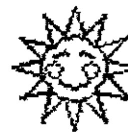
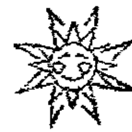
MOOREHEAD-ARDELT: QUALITY OF LIFE QUESTIONNAIRE

Self Esteem and Activities Levels

1. Compared to the time <u>before</u> my weight loss treatment I feel....

☐ Much Worse About Myself	☐ Worse About Myself	☐ The Same About Myself	☐ Better About Myself	☐ Much Better About Myself

2. I am able to participate <u>physically</u> in activities....

				
☐ Much Less	☐ Less	☐ The Same	☐ More	☐ Much More

3. I am willing to be involved <u>socially</u>....

☐ Much Less	☐ Less	☐ The Same	☐ More	☐ Much More

4. I am able to <u>work</u>....

☐ Much Less	☐ Less	☐ The Same	☐ More	☐ Much More

5. I am interested in <u>sex</u>....

☐ Much Less	☐ Less	☐ The Same	☐ More	☐ Much More

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