Gastric Bypass / Sleeve Surgery Follow-up Sheet

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 each day? .....yes/no
Are you taking 60mg Iron (ferrous fumarate) each day? .....yes/no
Are you taking a Calcium Citrate with Vitamin D3 each day .....yes/no
Are you taking 5000IU Vit 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

Symptoms	**Yes**	**No**
Dumping Syndrome		
Frothing		
Hair Loss		
Abdominal Pain		
Nausea		
Vomiting		
Difficulty with swallowing		
Heartburn or Reflux		
Constipation		
Diarrhea		
Fatigue		
Numbness or tingling of extremities		
Dizziness		
Headaches		
Memory Loss		
Vision Changes (i.e. at night, focusing, blurred)		
Hearing Changes		
Fever		
Breathing problems		
Possibility that you are pregnant or planning to become pregnant?		
Quality of Life, Current Rating: (circle one) *Very Satisfied, Satisfied, Somewhat Satisfied, Neutral, Somewhat Dissatisfied, Dissatisfied, Very Dissatisfied*		
Social History	**Yes**	**No**
Do you smoke? Amount per day?		

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Have you been taking aspirin, ibuprofen or NSAIDS?		
Do you drink alcohol? Amount per week?		
Do you use street drugs?		
Do you exercise?		
Times per week? 1 2 3 4 5 6 7		
Do you attend support group?		
Diet History	**Yes**	**No**
Tolerating meats/solid foods?		
Drinking Sodas?		
Food cravings?		
What type of cravings:		
Eating Sweets?		
Portion sizes (compare to before surgery meals) 25% 50% 75% 100%	X	X
How many hours after a meal are you hungry? 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?		

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

_____

_____

_____

_____

Patient Signature / Date

RNY / SLEEVE 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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