

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 dayyes/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) <i>Very Satisfied, Satisfied, Somewhat Satisfied, Neutral, Somewhat Dissatisfied, Dissatisfied, Very Dissatisfied</i>		
Social History	Yes	No
Do you smoke? Amount per day?		

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 – 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:** _____

MOOREHEAD-ARDELT: QUALITY OF LIFE QUESTIONNAIRE Self Esteem and Activities Levels

1. Compared to the time before 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 physically in activities....



Much Less



Less



The Same



More



Much More

3. I am willing to be involved socially....



Much Less



Less



The Same



More



Much More

4. I am able to work....



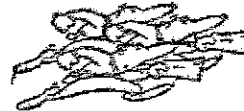
Much Less



Less



The Same



More



Much More

5. I am interested in sex....



Much Less



Less



The Same



More



Much More