



Gastric Bypass / Sleeve Surgery Follow-up Sheet

How many glasses of water or other hydration fluid 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 twice each day? yes/no
 Are you taking Iron twice each day? yes/no
 Are you taking Calcium Citrate with Vitamin D three times each day/ yes/no
 Are you taking B12 Supplement under the tongue once 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		
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?		
Have you been taking aspirin, ibuprofen or NSAIDS?		
Do you drink alcohol?		
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