



3240 Burnt Mill Drive ◊ Suite 1 ◊ Wilmington, NC 28403 ◊ Tel: 910-790-9500 ◊ Fax: 910-796-8111

POST OPERATIVE NUTRITION ASSESSMENT

Name: _____ Date: _____

Mailing Address: _____

City: _____ State _____ Zip Code _____

Email Address: _____

Home Phone: _____ Work Phone _____ Cell Phone: _____

What is the best way to contact you? _____ Is it okay to leave a message? Yes No

Date of surgery: _____ Surgeon's name: _____

Surgery: (circle one) Bypass Band Sleeve Current weight: _____

Total weight loss since surgery: _____ Height: _____

1. Check off any of the following that you are experiencing:

- | | |
|---|---|
| <input type="checkbox"/> Nausea episodes | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Vomiting episodes | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Dumping syndrome (after eating you
get one or more of the following
symptoms: flushing, sweatiness,
rapid heartbeat, dizziness, cramping) | <input type="checkbox"/> Food gets stuck |
| | <input type="checkbox"/> Dizziness, especially when going
from sitting to standing |
| | <input type="checkbox"/> Excessive fatigue |

2. For each box checked Question 1, please list the triggers or causes: : _____

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3. Other symptoms/complaints: _____

4. Please write down what you eat and drink on a typical day (approximate time, foods/amount, fluids/amount): _____

5. Do you have a protein at most meals or snacks? Yes / No Amount: _____

6. Do you drink liquids with meals? Yes / No Amount: _____

7. Do you drink carbonated beverages? Yes / No Amount: _____

8. Do you drink alcohol? Yes / No Amount: _____

9. How many ounces of clear liquids do you drink in a day? _____

10. Are you taking a multivitamin with minerals/iron daily? Yes / No (list type): _____

11. Are you taking a calcium supplement daily? Yes / No (list type): _____

12. List other vitamins or supplements that you take: _____

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13. **Check off the answer that describes you:**

- | | |
|---|---|
| <input type="checkbox"/> I never get hungry | <input type="checkbox"/> I plan and prepare most of my meals and make time to sit and eat mindfully |
| <input type="checkbox"/> I get hungry sometimes | <input type="checkbox"/> I practice eating slowly |
| <input type="checkbox"/> I am hungry throughout the day | |

14. List foods and beverages that are NOT tolerated: _____

15. Do you exercise regularly? Yes / No Type of activity: _____

16. How many days a week do you exercise? How many minutes? _____

17. Are you having difficulty adjusting to your diet? Yes / No Please explain. _____

18. Do you need additional therapy or dietitian visits? Yes / No

Signature: _____ Date: _____