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

POST-OPERATIVE NUTRITION ASSESSMENT

Name:____ DOB: ______________________

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:

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

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

____

____

3. Other symptoms/complaints: ____

____

____

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

____

____

____

____

© 2010. All rights reserved. Revised 08.01.2018

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: ____

____

____

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

- ☐ I never get hungry
- ☐ I get hungry sometimes
- ☐ I am hungry throughout the day
- ☐ I plan and prepare most of my meals and make time to sit and eat mindfully
- ☐ I practice eating slowly

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:________________________

© 2010. All rights reserved. Revised 08.01.2018