# Questionnaire & Assessment

**Patient Name** _____**Date**_____

*****General Surgery patients please fill out page 1 only*****

**If you had surgery: (please circle)** Lap Band Sleeve Gastric Bypass
Other**:** _____
**Approximate Date** _____
**Where/Who performed**: Dr Keith or Other: _____
**Did you have Gastric Balloon?** Yes No **Has it been removed?** Yes No

**Weight before weight loss procedure**_____ **Lowest weight achieved**_____

## Health History

**Please check those that apply and state frequency since your** LAST VISIT **with us:**

- ❑ Incision Concerns _____
- ❑ Nausea/Vomiting _____
- ❑ Heartburn/Reflux _____
- ❑ Constipation/Diarrhea _____
- ❑ Dizziness/Fainting _____
- ❑ Chest Pain/Pressure _____
- ❑ Heart Palpitations _____
- ❑ Swelling-Feet/Ankles _____
- ❑ Shortness of Breath _____
- ❑ Hair Thinning/Loss _____
- ❑ Alcohol or Caffeine consumption:_____
- ❑ Tobacco Use or Vaping: _____

**Please check those that apply and state when/where since your** LAST VISIT **with us:**

- ❑ **ER visits or Hospitalizations?**_____
- ❑ **Outpatient Blood Work?** _____
- ❑ **Procedures/Surgeries?** _____

**How long does it take to eat a meal?** 15 min 15-30 min 30-60 min 60 min or more

**How long after meals do you feel hungry again?**_____
**Do you measure your food?** YES NO
**How do you measure?** Measuring Cups Scale Eyesight Other:_____

**How many "cups" of food per meal?**_____ **How many Meal Replacements daily?**_____

**Describe your exercise: _____**

_____

**Describe a typical meal:**

Breakfast: _____

Lunch: _____

Snack: _____

Dinner: _____

Late Snack: _____

Estimated Fluids consumed daily _____ounces.

**<u>LAP BAND</u> Patients Only:**

- ❑ Band Fill is Perfect
- ❑ Need Fluid
- ❑ I Don't Know

Office Use Only:
Fluid Removed/Added_____cc ~ Total: _____cc

Today's Weight _____

_____ _____ **=** _____
+/-Weight Change since last visit # Weeks between visits Weekly change (#'s)