Two Week Post Surgery Assessment

Name: _____ Today's Date: _____
Date of Surgery: _____ Today's Weight: _____
Type of Surgical Procedure: _____

1. Did you have complications after bariatric surgery that affected your ability to follow the diet guidelines? ☐ Yes ☐No
   If yes explain: _____
2. List all medications you are currently taking:
   _____ _____ _____
   _____ _____ _____
   _____ _____ _____
3. Check any of the following you are currently experiencing
   ☐Vomiting episodes ☐Dumping syndrome ☐Constipation
   ☐Diarrhea ☐Nausea episodes
4. For each box checked in question 3, please list the triggers or cause: _____
5. How many ounces or servings of "full" liquid do you consume every day (this includes protein shakes, milk, yogurt, etc.)? _____
6. If you were unable to consume the minimum recommended amount of full liquid, explain why. _____
7. How many ounces or glasses of "clear liquid (water and other calorie –free, noncarbonated liquids) have you been able to consume every day? _____
8. Have you started taking your daily multivitamins? ☐ No ☐Yes
   If yes list type _____
9. Have you started taking a calcium supplement (Bypass patients only)? ☐ No ☐Yes
   If yes list type _____
10. Have you started taking your B-12 vitamin (Bypass patients only)? ☐ No ☐Yes
11. Have you started taking your vitamin D supplement (Bypass patients only)? ☐ No ☐Yes
12. Are you participating in your support group? ☐ No ☐Yes