

Ellner Bariatric GASTRIC BYPASS

Name: _____

Date _____

What is your main concern? _____

How many times do you eat solid food daily? One Two Three Other _____

What do you eat and when? _____

Is at least 50% of your meal lean protein? Yes No If no; why? _____

What is your "Low Blood Sugar" feeling? _____

Do you ALWAYS wait for your low blood sugar feeling before you eat solid food? Yes No

If "No", how often do you eat without feeling low blood sugar?

Never Occasionally, several times a week Frequently, at least everyday

What time of day does this usually occur? _____

What are your usual snack foods? _____

How many grams of protein do you get JUST IN YOUR DRINKS per day? _____

How much water do you drink in a 24 hour period?

64 ounces (8 cups) or more 4-7 cups, at least 24 ounces (3 cups) or less

What do you drink other than water? _____ How much? _____

Vitamins: Do you take them every day?

Yes Name of your multivitamin _____ How many? _____

No If no, how often? _____

Sublingual B12? Yes No How often? _____

Calcium Yes No Name _____ Dosage _____

Iron Yes No Name _____ Dosage _____

B Complex Yes No Name _____

Current medications: _____ Frequency: _____ Dosage: _____

_____ Frequency: _____ Dosage: _____

Exercise per week:

Cardio: Less than once intermittently 2-3 times 3-5 times 4-6 times daily

Duration: 30 minutes 30-60 minutes more than 60 minutes

What activity do you do for cardio? _____

What is your goal heart rate? _____ Actual heart rate during cardio _____

Weight Lifting: Less than once intermittently 2-3 times 3-5 times 4-6 times daily

What kind of weight lifting do you do? _____

Do you have sugar or fat intolerances? No Yes Comments _____

How often do you attend support group? _____

Are you happy that you had the surgery? Yes No