Ellner Bariatric GASTRIC SLEEVE

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: __________

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