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:** _____

_____ **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