# Whole Health Weight Loss Institute

Scott Perryman, MD, FACS, FASMBS

## Bariatric Surgery Follow-Up Questionnaire

*Please complete this questionnaire before your follow-up visit and bring it with you, or submit it online.*

**IMPORTANT:** If you are having chest pain, trouble breathing, severe abdominal pain, or heavy bleeding, call 911 or go to the nearest emergency room. Do not wait for your appointment.

Name: _____ Date of Birth: _____ Date: _____

### Time Since Surgery

How long ago was your surgery? *(circle one)*

☐ 2 weeks ☐ 6 weeks ☐ 3 months
☐ 6 months ☐ 9 months ☐ 1 year
☐ 2 years

### Symptoms Since Surgery

Have you experienced any nausea? ☐ Yes ☐ No

Have you experienced any vomiting? ☐ Yes ☐ No

Have you experienced any regurgitation? ☐ Yes ☐ No

Or reflux? ☐ Yes ☐ No

### Weight & Nutrition

How much weight has been lost? _____ lbs

Are you taking a daily multivitamin? ☐ Yes ☐ No

Are you taking other prescribed medication (Pantoprazole / Ursodiol)? ☐ Yes ☐ No

How much water have you been drinking on a daily basis? _____ oz

How many grams of protein are you taking in daily? _____ g

### Exercise

Are you exercising? ☐ Yes ☐ No

How often do you exercise? (times per week) _____

What have you been doing for exercise? _____

How long do you exercise? _____ minutes

### Medications

Were you taking any medications before surgery? ☐ Yes ☐ No

If yes, have you stopped any of those medications? ☐ Yes ☐ No

If yes, which medications did you stop? _____

### Emergency Room & Hospital

Have you been to the emergency room since surgery, within 60 days of surgery? ☐ Yes ☐ No

If yes, were you admitted to the hospital within 90 days of surgery? ☐ Yes ☐ No

Reason why? _____

### Symptoms Since Last Visit

*Since your last visit have you experienced any symptoms? (circle all that apply)*

☐ Blurred vision ☐ Double vision ☐ Loss of vision
☐ Loss of consciousness ☐ Chest pain ☐ Palpitation

- ☐ Shortness of breath
- ☐ Cough
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in the stool
- ☐ Pain with urination
- ☐ Blood in the urine
- ☐ Frequent urination
- ☐ Tingling (hands or feet)
- ☐ Weakness
- ☐ Fevers
- ☐ Chills

Other symptoms not mentioned above: _____

## Diet Sample

| Meal | Meal Time | Meal Description |
|---|---|---|
| **1st Meal** | | |
| **2nd Meal** | | |
| **3rd Meal** | | |
| **Snacks** | | |

Patient Signature: _____ Date: _____

*You can also complete this form online — ask our office for the link.*

575 Lincoln Avenue, Suite 210 · Napa, CA 94558 · (707) 721-3500 · Fax: (707) 721-3499 · office@whweightloss.com