Post-operative Visit Name: _____ Appointment date:_____

Circle any specific problems:

Abdominal pain	Constipation	Weight gain	
Nausea or vomiting	Diarrhea	Wound problems	
Reflux	Swallowing problems	Other:	

Protein intake (grams)

<30	40-60	70-90	>100

Fluid intake (ounces)

<30	40-60	70-90	>100

Vitamins:

ADEK Multivitamin	Multivitamin	Calcium	Vitamin D	Iron
Biotin	Vitamin A	Vitamin K	Vitamin E	Other

Are you eating healthy foods?

Yes	No	Sometimes	Non consistently

Please circle any challenging eating habits:

Carbs (Bread/Pasta)	Fried foods	Soft drinks (sugar)	Salty Snacks (Chip)	Other
Grazing	Large meals	Skipping meals	Eating late	

Are you exercising: Yes No (Circle details below)

Frequency	2 times/ week	3 times/week	4 times/week	>5 times
Time	About 15 minutes	30-45 minutes	1 hour	>1hour
Cardio (walking, biking, etc)		Strength (resistance, weight lifting)		

Did you draw labs for today's visit? Yes No

_____

_____

_____

_____

Plan

_____

_____

_____

Follow-up