Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

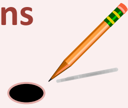
Lap Band Follow Up

4 week and successive follow up visits

PLEASE PRINT PATIENT'S LAST NAME

Marking Instructions

Please use a # 2 pencil
Fill in the complete oval as shown...



PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Do you eat breakfast?
yes ◯ no ◯

How many meals do you eat per day?
1 ◯ 2 ◯ 3 ◯ 4 ◯ graze ◯

Are you hungry between meals?
yes ◯ no ◯

Please indicate foods that you CANNOT eat.
(Mark all that apply)
beef ◯ chicken ◯ fish ◯ bread ◯ salad ◯ pizza ◯ fruit(s) ◯

How often do you eat high calorie snacks?
(i.e. ice cream, sweets, chips, cookies)
rarely ◯ 1 – 2 times per week ◯ 3 – 4 times per week ◯ daily ◯

Do you drink any beverages that are high in calories?
(i.e. sodas, juices, sweet tea)
yes ◯ no ◯

Do you drink with meals?
never / < 10% of the time ◯ 10 – 25% of the time ◯ 25 – 50% of the time ◯ 50 – 75% of the time ◯ > 75% of the time ◯

Do you have reflux or heartburn?
yes ◯ no ◯

How many times have you vomited in the last 2 weeks?
NONE ◯ once ◯ 2 – 3 times ◯ every other day ◯ daily ◯

How many days per week do you exercise?
NONE ◯ 1 – 2 ◯ 3 – 4 ◯ 5 – 7 ◯

(U.S. Patent No. 7,487,102) (U.S. Patent No. 7,941,328)

SAMPLE

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