

Weight Loss Surgery Center at UMMC, Fairview

Band Assessment Form (Please fill out this form for every clinic visit.)

Section 1. Personal Contact Information

NAME: _____

e-mail address: _____

May we use your e-mail address for correspondence?

Yes No

Best phone number? _____

Section 2. Band Information

Date Placed _____/_____/_____

Surgeon _____

Type of Band? (if known) _____

Section 3. Prior Adjustment History

Seminar weight? _____ pounds

Last visit weight? _____ pounds

Current weight? _____ pounds

Date of last adjustment? _____

How many adjustments since surgery? _____

Date of last UGI (mo/year)? _____

Date of last weight loss labs (mo/year)? _____

What zone were you in before the last adjustment?

yellow (light fit) green (right fit) red (tight fit)

What zone do you think you are in now?

yellow (light fit) green (right fit) red (tight fit)

Section 4. Current Symptoms

How much weight per week have you been losing recently?

I'm gaining weight 0-1 1-2 2+

Are you hungry in the morning? yes no

Are you skipping breakfast? yes no

Do you need large meals to satisfy hunger? yes no

Can you easily eat and swallow chicken, steak, or bread (without mincing or dicing up)? yes no

Do you think you are eating too much? yes no

Are you looking for food between meals? yes no

How many times a day are you hungry? _____

Are you eating fast? yes no

Do you keep eating without stopping? yes no

Are you still hungry with just ½ cup of food 2 or 3 times per day with no snacks in between meals? yes no

Are you measuring your food? yes no

Section 5. Deflation Indications

Does your band become obstructed? yes no

Have you been vomiting? yes no

Are you planning to be pregnant? yes no

Do you have a significant illness? yes no

Will you be having general anesthesia? yes no

Are you having reflux or a new cough? yes no

Do you have regurgitation? yes no

Are you eating lots of chocolates, ice cream, milk drinks, pureed foods, yogurt, or snack foods (like potato chips)? yes no

Will you be traveling to remote areas? yes no

Will you be traveling to areas where food or water contamination is endemic? yes no

Section 6. Details of Adjustment (surgery team will complete this section)

Date of this adjustment _____

Surgeon/PA/NP _____

Port was difficult to access no yes

Next adjustment 2 weeks 1 month 2 months

6 months (never longer than 6 months)

Problems with water swallowing post-fill? no yes

Special notes about adjustment:

Comments about UGI:

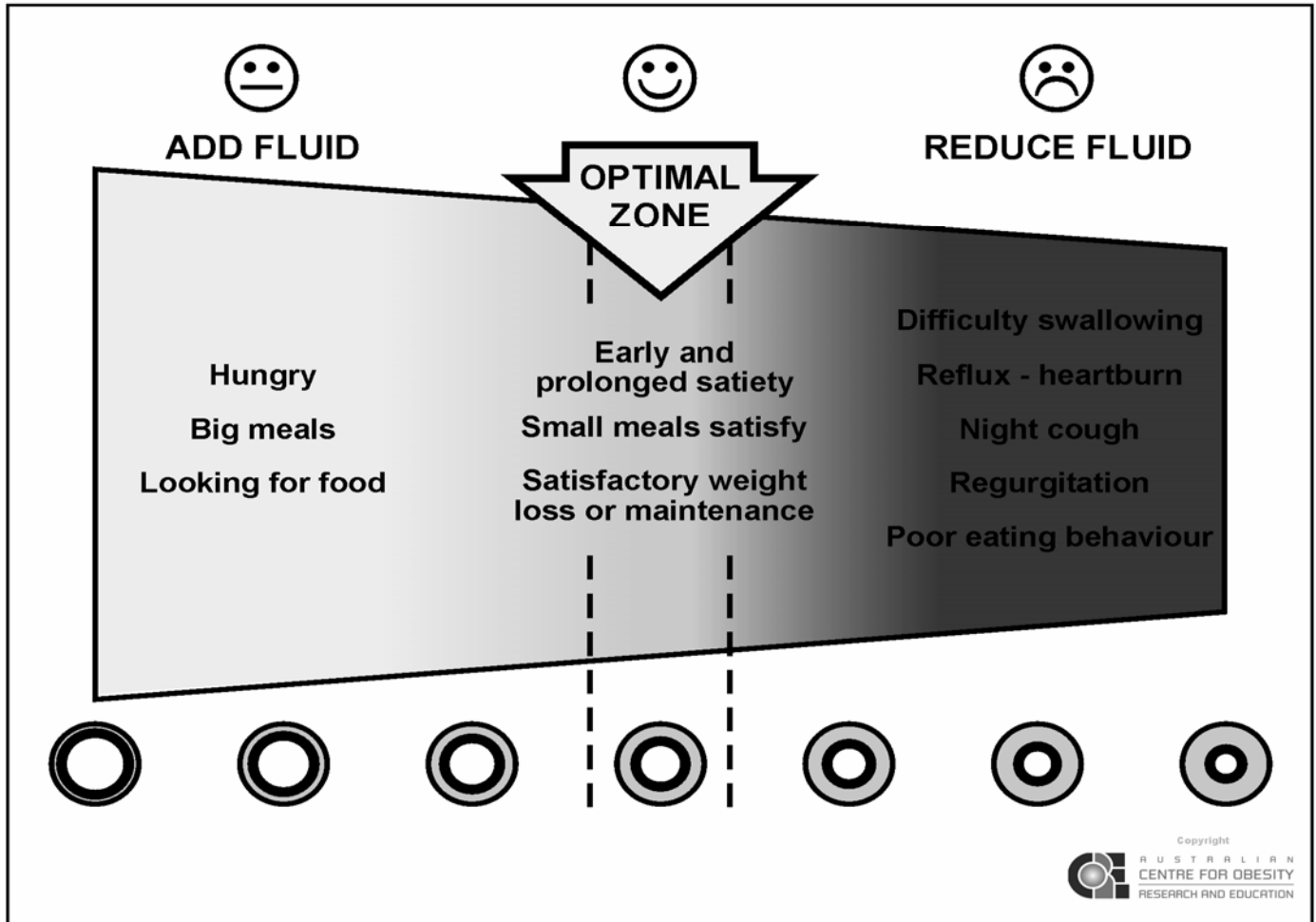
Choose one adjustment type: Fill Deflation
 No fill needed

Amount of saline added: mL

Amount of saline removed: mL

Total saline in system after adjustment mL

Please circle your zone in the diagram below.



Ideal Band Diet (used to gauge hunger control).

1. $\frac{1}{2}$ cup of food 2-3 times/day.
2. Absolutely no liquid calories (at body temperature). i.e. no ice cream, no slimfast, no soups. Foods that pour off a spoon (at body temperature) will defeat band surgery.
3. Avoid any calories (snacking) between meals.
4. Skip breakfast if you are not hungry in the morning (the band is usually tighter in the morning).
5. Eat slowly (20-30 minutes) to avoid too rapid distension of the pouch, which could lead to slippage or pouch dilation.