SANDOVAL REGIONAL MEDICAL CENTER

THE UNIVERSITY OF NEW MEXICO HEALTH SCIENCES CENTER

Welcome!

Thank you for choosing UNM Sandoval Regional Medical Center for your healthcare needs. Not everyone meets the criteria for weight loss surgery, so we will learn more about you to find out if you are eligible to have surgery and to decided how we can make this experience best for you. By filling out the required forms, attending all appointments, and having your primary care provider to send us your medical records, you will help the process tremendously.

Here are some of the steps you need to take in our pre-surgical approval process:

- Do you have Insurance? If so, you will need to call them and ask if you have coverage for weight Loss Surgery. Be sure to ask about the specific insurance plan you currently have by confirming the information on your insurance card.
- Complete this entire packet. It includes a Medical Release consent form, an Insurance Information form, Questionnaire regarding your medical and psychological history, a form for your Primary care Physician and ALL specialists you have been seen by.
- Fill out medical information release form completely. This allows us permission to request your medical records, we require at least one year of records.

Once you have completed everything, please return it to our office so we can start the process.

Please return your completed packet one of the following ways:

-Email: jorubi@unmmg.org
-Fax: 505-994-7631
-Mail: *UNM Bariatric Program*
Sandoval Regional Medical Center
3001 Broadmoor Blvd NE
Rio Rancho, NM 87144

Please call if you have any questions or need help getting through this process. You can reach our coordinators:

Joanna Rubi, BSN, RN -Bariatric Clinical Nurse Coordinator

Leann Misquez -Bariatric Clinic Coordinator

Department of Surgery
MSC10 5610
1 University of New Mexico
Albuquerque, NM 87131
Phone: 505-272-6191

Dr. Steven Bock
Dr. Ethan Benning
Camella Hernandez, CNP

SANDOVAL REGIONAL MEDICAL CENTER

THE UNIVERSITY OF NEW MEXICO HEALTH SCIENCES CENTER

Bariatric Program Pre-Surgical Checklist

1. __ View Bariatric Zoom Seminar https://unmhealth.org/services/bariatric/ click "view seminar"
2. __ Verify your personal benefits with your insurance company.
3. __ Return your completed Medical Questionnaire.
4. __ Return your completed quiz
5. __ Return your signed Release Consent Form.
6. __ Return completed list of Providers names and contact information.
7. __ Complete all ordered labs at any **Tricore Lab** one week prior to your Bariatric Consult.
8. __ Bariatric Consult will determine whether you are an appropriate candidate:
    a. BMI > 40
    b. BMI 35-40 with obesity-related health problems such as; diabetes, severe reflux, sleep apnea, DJD, coronary heart disease, etc.
9. __ Meet with our Registered Dietician for a one hour consult followed by a minimum of 2 additional dietary classes.
10. __ Complete a Bariatric Evaluation with our Psychologist after your Bariatric Consult.
11. The following are some studies, conditions or additional steps that may be required. If already done we will need the reports:
    a. Colonoscopy- Any patient over 50 years old or over 40 with a family history of colon cancer
    b. Mammogram- Any female patient over 50 or over 40 with family history of breast or ovarian cancer
    c. Sleep Study
    d. Controlled diabetes with an A1C less than 8 prior to surgery
12. __ No use of:
    a. Nicotine of any kind- cigarettes, chew, and nicotine patches.
    b. Recreational Drugs
    c. Alcohol abuse

All of these are very important to the timeline of your upcoming Bariatric Surgery!

SANDOVAL REGIONAL MEDICAL CENTER

THE UNIVERSITY OF NEW MEXICO HEALTH SCIENCES CENTER

Patient Questionnaire – Bariatric Surgery

Name: _____ M/F: _____ DOB: _____ Age:_____

Date of Seminar: _____ Insurance: _____

Address: _____ Phone Number: _____

E-Mail: _____ Transportation: Car/Bus/SunVan/Medical Transport

Mobility Issues: None/walker/Wheelchair Reside in: House/Apartment/ Mobile Home/Other

Language: English/Spanish/Navajo/Other: _____ Interpreter: Yes/No

History of Bariatric Surgery: Lap Band/ Sleeve/ Gastric Bypass Date: _____

Family History – Please mark "x" to all that apply:

Family Member	Obesity	Diabetes	Heart Disease	High Blood Pressure	High Cholesterol	Cancer (type)	Other
Father							
Mother							
Grandparents							
Siblings							
Children							

Medications – Please include ALL medications you take regularly (prescription and over-the-counter). Please also include ALL vitamins, supplements, or herbals:

Name of medication/Vitamins	Dose-How much do you take	How often?	Start Date?

Do you have any allergies to any medications or foods? ☐Yes ☐No If "yes", please list:

_____

_____

Do you have an allergy to Latex or surgical tape? ☐Yes ☐No If "yes", please list: _____

_____

Have you had any previous surgeries? ☐Yes ☐No If "yes", please list:

Surgery type	Year	Surgery type	Year

SANDOVAL REGIONAL MEDICAL CENTER

THE UNIVERSITY OF NEW MEXICO HEALTH SCIENCES CENTER

Other Medical History - Please list **ALL** other medical history or reasons why you currently seek the care of a physician:

For women only: Are you currently pregnant? ☐Yes ☐No Are you planning to become pregnant? ☐Yes ☐No

Are you currently breastfeeding? ☐Yes ☐No Age at menopause: _____

Current Medical Conditions (please check yes or no for those that apply)

General Information:

High blood pressure	□ Yes	□ No
Heart Disease	□ Yes	□ No
Pulmonary disease/asthma/COPD	□ Yes	□ No
Cancer	□ Yes	□ No
If yes, what kind?		
Thyroid problems	□ Yes	□ No
History of transplant	□ Yes	□ No
If yes, what kind?		

General Information:

On Medication	□ Yes	□ No
Diabetes	□ Yes	□ No
Seizure disorder	□ Yes	□ No
Depression	□ Yes	□ No
Mental illness	□ Yes	□ No
Gout	□ Yes	□ No

Eyes

Blurring	□ Yes	□ No
Double vision	□ Yes	□ No
Irritation/infections	□ Yes	□ No
Eye pain	□ Yes	□ No
Spots or floaters	□ Yes	□ No
Changes in vision	□ Yes	□ No
Glasses	□ Yes	□ No
Contacts	□ Yes	□ No

General

Fevers	□ Yes	□ No
Night Sweats	□ Yes	□ No
Chills	□ Yes	□ No
Fatigue	□ Yes	□ No

Ears/Nose/Throat

Earaches	□ Yes	□ No	
Discharge from ears	□ Yes	□ No	
Ringing in ears	□ Yes	□ No	
Decrease in hearing	□ Yes	□ No	
Hearing aids (circle one):	□ Yes	□ No	
Recurrent head colds	□ Yes	□ No	
Sinus troubles	□ Yes	□ No	
Dysphagia (difficulty swallowing)	□ Yes	□ No	
Change in taste	□ Yes	□ No	
Change in smell	□ Yes	□ No	
Persistent hoarseness	□ Yes	□ No	
Recurrent sore throats	□ Yes	□ No	
Recurrent sores in mouth	□ Yes	□ No	
Enlarged glands	□ Yes	□ No	
Soreness or bleeding from gums when brushing	□ Yes	□ No	
Dentures (circle one):	□ Top	□ Bottom	□ Both
Partials (circle one)	□ Top	□ Bottom	□ Both
Permanent bridges or implants	□ Yes	□ No	

Cardiovascular

Chest pain	□ Yes	□ No
Angina	□ Yes	□ No
Palpitations	□ Yes	□ No
Fainting spells	□ Yes	□ No
Shortness of breath:		
Walking several blocks	□ Yes	□ No
One flight of stairs	□ Yes	□ No
When laying down	□ Yes	□ No
Wake up at night	□ Yes	□ No
High blood pressure	□ Yes	□ No
Swelling of hands or feet	□ Yes	□ No
Varicose veins	□ Yes	□ No
Heart disease	□ Yes	□ No
Circulation problems	□ Yes	□ No
High cholesterol	□ Yes	□ No

SANDOVAL REGIONAL MEDICAL CENTER

THE UNIVERSITY OF NEW MEXICO HEALTH SCIENCES CENTER

Endocrine

Heat intolerance	□ Yes	□ No
Cold intolerance	□ Yes	□ No
Hot flashes	□ Yes	□ No
Brittle nails	□ Yes	□ No
Change in skin texture	□ Yes	□ No
Change in hair texture	□ Yes	□ No

Skin

Rashes	□ Yes	□ No
Lesions	□ Yes	□ No
Itching	□ Yes	□ No
Dryness	□ Yes	□ No
Eczema	□ Yes	□ No
Psoriasis	□ Yes	□ No

Hematologic/Lymphatic

Abnormal bruising or bleeding	□ Yes	□ No
Enlarged lymph nodes	□ Yes	□ No
Blood or plasma transfusion	□ Yes	□ No

Genitourinary

Urinary frequency, times per day	_____	
Do you feel like you empty your bladder?	□ Yes	□ No
Pain with urination	□ Yes	□ No
Difficulty starting urination	□ Yes	□ No
Get up at night to urinate	□ Yes	□ No
Urinate more than before	□ Yes	□ No
Blood in your urine	□ Yes	□ No
Loss of urine with coughing or sneezing	□ Yes	□ No

Males:

Discharge from penis	□ Yes	□ No

Females:

Vaginal discharge	□ Yes	□ No
Painful periods	□ Yes	□ No
Polycystic ovarian disease	□ Yes	□ No
Irregular periods	□ Yes	□ No
How many pregnancies?	_____	
Live births:	_____	
Still births:	_____	
Miscarriages:	_____	
Cesarean sections:	_____	

Allergic/Immunologic

Hay fever	□ Yes	□ No
Recurrent infections	□ Yes	□ No
HIV / Exposure	□ Yes	□ No

Gastrointestinal

Stomach pain or cramping	□ Yes	□ No
Heartburn	□ Yes	□ No
If yes, how do you treat?	_____	
Nausea or vomiting	□ Yes	□ No
Diarrhea	□ Yes	□ No
If chronic, has it been evaluated?	□ Yes	□ No
Constipation	□ Yes	□ No
If chronic, has it been evaluated?	□ Yes	□ No
Bleeding from rectum	□ Yes	□ No
If yes, has this been evaluated?	□ Yes	□ No
Vomiting of blood	□ Yes	□ No
Hemorrhoids	□ Yes	□ No

Neurological

Headaches	□ Yes	□ No
Migraine Headaches	□ Yes	□ No
Dizzy spells	□ Yes	□ No
Paralysis	□ Yes	□ No
Change of sensation in hands or feet	□ Yes	□ No
Tingling of hands or feet	□ Yes	□ No
Seizures	□ Yes	□ No
Tremors	□ Yes	□ No
Head injuries	□ Yes	□ No
Knocked unconscious	□ Yes	□ No

Respiratory

Cough	□ Yes	□ No
Cough when lying down	□ Yes	□ No
Sleep on more than one pillow	□ Yes	□ No
Shortness of breath	□ Yes	□ No
Coughing up blood	□ Yes	□ No
Wheezing or asthma	□ Yes	□ No
Sleep apnea diagnosed	□ Yes	□ No
Sleep apnea symptoms only, no tests	□ Yes	□ No

□ CPAP □ BiPAP □ Other: _____

Musculoskeletal

Back pain/backaches	□ Yes	□ No
If yes, has it been evaluated?		
Joint pain: knees, hips, or ankles	□ Yes	□ No
Joint swelling	□ Yes	□ No
Muscle spasms	□ Yes	□ No
Leg cramps	□ Yes	□ No
Muscle weakness	□ Yes	□ No
Stiffness	□ Yes	□ No
Arthritis	□ Yes	□ No

Assistive Devices:

□ Cane □ Crutches
□ Walker □ Wheelchair
□ Prosthesis □ Other: _____

Psychiatric

Depression	□ Yes	□ No
Have you ever been treated for drugs or alcohol?	□ Yes	□ No
Dependency:		
Anxiety	□ Yes	□ No
Memory loss	□ Yes	□ No
Suicidal ideation	□ Yes	□ No
Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD)	□ Yes	□ No
Bipolar disorder	□ Yes	□ No
Schizophrenia	□ Yes	□ No
Paranoia	□ Yes	□ No
Hallucinations	□ Yes	□ No

Other: _____

****The following section is related to your diet, weight, and lifestyle. Please completely fill out each section and answer questions honestly. You and your dietitian will review this section together on your initial nutrition visit*****

Weight Loss Programs/Methods: Please check all programs you have tried

	Year	Wt Loss (lbs)	Wt. gain (lbs)	Additional information
□ Acupuncture				
□ Alli				
□ Atkins (protein diet)				
□ Body Connection				
□ Calorie Counting				
□ Diabetic Diet				
□ Diet (cutting back)				
□ Diet Center				
□ Diet Pills OTC (Dexatrim, etc.)				
□ Redux				
□ Diet Pills Rx				
□ Phentermine				
□ Phen Fen				
□ Dr. Phil's Ultimate Weight Loss				
□ Ephedra (ma huang)				
□ Exercise Programs				
□ Fasting				
□ Fat free diets				
□ Glycemic Index				
□ Herbal Diet				
□ Herbal Life				
□ Herbal tea				
□ High Protein				
□ Hydroxycut				
□ Hypnosis				
□ Inpatient psychiatric program/ psychotherapy				
□ Jenny Craig				
□ LA Weight Loss				
□ Liquid diets (Slim Fast, etc.)				
□ Mayo Clinic				
□ Medifast				
□ NutriSystem				
□ Optifast				
□ Overeaters Anonymous				
□ Richard Simmons diet				
□ South Beach				
□ TOPS (taking off pounds sensibly)				
□ Vegetable diets				
□ Weight Watchers				

How many years have you been obese?_____
Please be specific with when you were on the plan, how much weight you lost and how much gained.
The last 3-5 years are the most important.

Have you ever seen a dietitian before? ☐Yes ☐No
If "yes", for what reason? _____When? _____Where?
_____

Have you ever been diagnosed with an eating disorder? ☐Yes ☐No

If "yes", what type? ☐Binge Eating ☐Anorexia Nervosa ☐Bulimia ☐Other_____

Were you ever treated in an inpatient rehab due to your weight? ☐Yes ☐No

If "yes", where? _____

Has a physician ever supervised your attempts to lose weight? ☐Yes ☐No
If "yes", please list the Doctors you have seen for weight loss:

Doctor/Clinic	City	Treatment Dates	Type of Treatment

Height:
Current Weight:
BMI (if known):
Highest adult weight:
Lowest adult weight:
Recent weight change? ☐Yes ☐No How many pounds lost?_____ Gained?_____
What would you like to weigh?
How much weight do you expect to lose as a result of weight loss surgery? ☐Less than 50 lbs. ☐50-100 lbs. ☐100-150 lbs. ☐More than 150 lbs.
What age did you begin to gain excess weight?
Looking back, what would you attribute the weight gain to at that time?

Do you drink alcoholic beverages? ☐Yes ☐No
If "yes", how often?
_____
If "yes", what do you drink? ☐Beer (regular) ☐Beer (light) ☐Wine ☐Mixed drinks ☐Brandy ☐Liquor (Gin, Rum, Vodka)
Do you use marijuana, cocaine, crack, or other recreational drugs? ☐Yes ☐No
Do you smoke? ☐Yes ☐No
If "yes", how much do you smoke in 24 hours?
_____
If "no", have you ever smoked? ☐Yes ☐No If "yes", when did you quit?
_____

How many hours do you usually sleep (out of a 24 hour day)?_____
What time do you usually wake up? _____What time is your first meal? _____

Do you follow any religious or cultural rules that influence what or how you eat? ☐Yes ☐No
If "yes", please explain_____

How do you learn best? ☐Verbal (explanation/audio tapes) ☐Demonstration (in person/video) ☐Written (books/pamphlets) ☐Other_____

Please check (✓) everything below that describes your diet and/or lifestyle behaviors:

	I eat large portions, get seconds, or overfill my plate		I get less than three dairy servings daily (milk, yogurt, cheese)
	I skip meals or go for longer than five hours between meals		I eat too quickly, chew foods poorly, or take too large of bites
	I dine out (including carry-out) more than three times a week		I am an emotional eater or I eat more when I am stressed
	I frequently eat fried foods, fast foods, and high fat foods		I drink less than 64 ounces (8 cups) of fluids daily
	I frequently eat sweets and desserts (candy, cakes, cookies, pies)		I gulp, rather than sip, my beverages or drink too quickly
	I graze (snack on food all day long) while doing other things such as reading, computer work, watching TV		I drink beverages with calories (juice, punch, soda, sweet tea, etc.)
	I eat high calorie snacks		I usually drink more than two carbonated drinks daily (soda pop, bubbly drinks)
	I wake up and eat during the middle of the night		I usually drink more than two cups of coffee or caffeine drinks daily
	I do not eat enough protein (less than 4-6 ounces of meat, fish, or poultry daily)		I lack sufficient exercise (less than 30 minutes on most days of the week)

Please check (✓) those statements below that apply to you.

	I have a relative or a friend who may try to hinder /delay my weight loss efforts		In the past I have not been good about taking vitamins and/or medications
	I rely on someone else to purchase/buy and/or prepare/make my food		English is not my first language. I have a language barrier
	I have problems with chewing and swallowing		My calorie intake is already low (below 1000 calories/day)
	I have a physical condition(s) that limits activity or exercise		I am a stress eater or emotional eater
	I have an eating disorder		I have problems with eyesight or hearing
	I have a difficult work schedule		I never feel full even when I have eaten a lot
	I may not be able to afford supplements		I would have a difficult time reducing or giving up the following foods:

Please complete the following sentences:

The main reason I have been unable to lose weight (or maintain lost weight) is because:_____

_____

I want to lose weight (or I have decided to have weight loss surgery) because:_____

_____

Questions I would like to discuss with the dietitian are:_____

_____

Please describe your usual daily eating pattern in the grid below the following example:

Time	Meal	Foods and Beverages (include amounts and how food is prepared)
8:30am	Breakfast	1 cup coffee with 3 teaspoons sugar and 1 creamer, three pancakes with butter and syrup, four slices bacon
10:45am	Snack	Six Oreo cookies, 12oz cup of 2% milk
7:00pm	Dinner	2 fried chicken breasts (extra crispy), ½ cup green beans with ham, 1 cup mashed potatoes with ¼ cup gravy, 2 biscuits with 2 tablespoons butter and 2 tablespoons honey, 2 cans of beer

Time	Meal	Foods and Beverages (include amounts and how food is prepared)
	Breakfast	
	Snack	
	Lunch	
	Snack	
	Dinner	
	Snack	

Epworth Sleepiness Scale

This questionnaire will help your physician to measure your general level of daytime sleepiness.

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?
This refers to your usual way of life in recent times.
Even if you haven't done some of these things recently, try to work out how they would have affected you.
Use the following scale to choose the *most appropriate number* for each situation:

Situation	**Chance of Dozing**			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (e.g. a theater or a meeting)	0	1	2	3
As a passenger in a car for an hour without break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

SANDOVAL REGIONAL MEDICAL CENTER

THE UNIVERSITY OF NEW MEXICO HEALTH SCIENCES CENTER

Medical Record Information

Name: _____

Date of Birth: _____

Please provide the name and contact information for each of these that you have been seen by:

Primary Care Physician:
Office Name: _____
Phone Number: _____
Fax Number: _____

Cardiologist (Heart):
Office Name:_____
Phone Number:_____
Fax Number:_____

Pulmonologist (Lungs):
Office Name:_____
Phone Number: _____
Fax Number:_____

Gastroenterologist:
Office Name:_____
Phone Number: _____
Fax Number: _____

Neurologist (Head):
Office Name:_____
Phone Number:_____
Fax Number:_____

Nephrologist (Kidney):
Office Name:_____
Phone Number:_____
Fax Number:_____

Oncologist (Cancer):
Office Name:_____
Phone Number: _____
Fax Number: _____

Rheumatologist:
Office Name:_____
Phone Number: _____
Fax Number: _____

Psychologist/ Psychiatrist:
Office Name:_____
Phone Number:_____
Fax Number:_____

If you have had the following, please complete:

Endoscopy:
Office Name:_____
Phone Number:_____
Fax:_____

Colonoscopy:
Office Name:_____
Phone Number:_____
Fax Number:_____

Mammogram:
Office Name:_____
Phone Number:_____
Fax Number:_____

Consent to Release Medical Records

I give UNMH permission (consent) to release all information about my medical history to my health insurance company (Medicaid, Medicare, etc.). This includes information about my Psychological evaluations, weight loss programs and other information.

All information regarding my past and present medical history may be copied and released to my insurance company, Medicare, Medicaid, etc. for pre-authorization for gastric bypass/lap band surgery due to morbid obesity.

Patient Signature:_____ **Date:**_____

How Can We Contact You?

May we leave a message on your answering machine at work or home? Yes_____ No_____

May we leave a message with your spouse or significant other? Yes_____ No_____

Patient Signature:_____ **Date:**_____

Insurance Information

Insurance Company Name:_____

Policy Number:_____

Group Name:_____

SANDOVAL REGIONAL MEDICAL CENTER

THE UNIVERSITY OF NEW MEXICO HEALTH SCIENCES CENTER

Bariatric Surgery Post Information Session Quiz

This quiz is not intended to be stressful or result in the cancelling of surgeries. **However**: Understanding what to expect after surgery and behavior changes that are necessary to be successful **is** the most important step of this entire process.

Please ask if you have any questions or you do not understand any questions.

Name: _____ Date: _____

Date that you viewed the patient information session: _____

Please read each question carefully and answer with **T** (True) or **F** (False)

1. _____ After surgery my diet will focus on eating protein based foods first.

2. _____ As long as I get my protein, it is ok to fill up on less healthy foods like bread and pasta.

3. _____ After the first few months, it is ok to drink fluids with my meals.

4. _____ Right after surgery, in order to drink at least 32 oz of water each day, I need to work at sipping all day long.

5. _____ Keeping a journal of foods, fluids and exercise that you have done will be helpful for you and the bariatric team in helping you lose weight.

6. _____ It is better to graze all day than to eat three meals each day.

7. _____ Each meal should take 15-30 minutes to finish.

8. _____ Once I am used to solid foods, chewing well is not such an issue.

9. _____ Bariatric Surgery is a tool that gives me about 1-2 years to establish healthy eating and exercise habits to prevent weight regain.

10. _____ I will not be able to take NSAID's (ibuprofen, Aleve and other arthritis medications) after bariatric surgery.

11. _____ Diabetes, high blood pressure, back pain and similar medical conditions are **guaranteed** to get better after bariatric surgery.

12. _____ Developing new behaviors after bariatric surgery is essential and will enhance weight Loss success.

13. _____ After surgery I will be able to eat anything and as much as I want and still lose weight.

14. _____ Re-Operation is necessary on rare occasions after bariatric surgery.

15. _____ If I have trouble swallowing, vomiting frequently, difficulty holding down fluids and do not know why, I should just wait a few days to see if symptoms improve before calling the bariatric nurse.

16. _____ After the first year I will not need to see the bariatric surgery team for follow-up appointments anymore.

17. _____ It is possible that emotional difficulties could occur after my surgery because of the many lifestyle changes that will occur.

18. _____ Long term weight loss is guaranteed after bariatric surgery.

19. _____ After gastric bypass surgery, sugars and high fat foods may cause Dumping Syndrome. Symptoms can include bloating, cramping, lightheadedness, fast heart rate, and sweating.

20. _____ After bariatric surgery, it is ok to drink soda and milk shakes and to eat candy, french fries, hamburgers, pizza and sweetened cereals.

21. _____ After the first year I will not have to take vitamins anymore and it will be ok to take Ibuprofen.

22. _____ Exercise has no effect on the amount of weight that I will lose after surgery.

23. _____ Alcohol consumption is not recommended after bariatric surgery.

24. _____ If continue to smoke I will be able to have bariatric surgery

25. _____ It is OK to restart smoking after I have recovered from bariatric surgery

26. _____ Attending monthly support group meetings can be helpful for long term success.

27. _____ Patients **never** have nausea or vomiting after bariatric surgery.

28. _____ Changes in bowel habits may occur.

29. _____ Once I have bariatric surgery, weight gain is not possible.

30. _____ Gastric Bypass and Sleeve Gastrectomy are easy operations and do not have any risks.

31. _____ Complications are always infrequent and minor, so you do not need to bother the bariatric team or the doctors with concerns.

32. _____ It is recommended that women wait at least 1 ½ - 2 years post-surgery before getting pregnant.

33. _____ I will need to get lab tests prior to some, but not all, of my follow-up appointments.

34. _____ If I am experiencing nausea and vomiting every day, I should just wait until my next appointment with the dietitian to bring it up. 3

35. _____ Journaling is beneficial for my dietitian and surgeon to see what my diet looks like, but it is also important for **me** to know my protein and fluid intake, my emotions, symptoms, and to see any patterns…positive or negative.

36. _____ I should rely only on protein drinks to get the required amount of protein each day.

37. _____ Smoking greatly increases the risk of developing ulcers, erosions, and perforations in both Gastric Bypass and Sleeve Gastrectomy patients.

38. _____ Chronic nausea is to be expected following surgery and I can just take anti-nausea pills to prevent it.

39. _____ The Gastric bypass has a greater chance than Sleeve Gastrectomy of causing reflux or making it worse.

40. _____The Gastric bypass has a greater chance of getting diabetic patients off of diabetes Medication.

41. _____ Patients on average will lose more weight with a Sleeve Gastrectomy than a Gastric Bypass.

Please submit this to our clinic after you have viewed the patient information session.

Email: jorubi@unmmg.org
Main Number: 505-994-7397
Fax Number: 505-994-7631
Mail: ***UNM Bariatric Program***
Sandoval Regional Medical Center
3001 Broadmoor Blvd NE
Rio Rancho, NM 87144