GENERAL CHECKLIST FOR POSTOP

2 week postop:          Date:_____________
  ☐ How are you feeling?
  ☐ Expected weight loss
  ☐ Nutrition  Beverages  Food  Vitamins /supplements
  ☐ Exercise

6 week postop:          Date:_____________
  ☐ How are you feeling?
  ☐ Expected weight loss
  ☐ Nutrition  Beverages  Food  Vitamins /supplements
  ☐ Exercise  Join a gym

3 month postop:         Date:_____________
  ☐ How are you feeling?
  ☐ Expected weight loss
  ☐ Nutrition  Beverages  Food  Vitamins /supplements
  ☐ Exercise

6 month postop:         Date:_____________
  ☐ How are you feeling?
  ☐ Expected weight loss
  ☐ Nutrition  Beverages  Food  Vitamins /supplements
  ☐ Exercise

1 year postop:          Date:_____________
  ☐ How are you feeling?
  ☐ Expected weight loss
  ☐ Nutrition  Beverages  Food  Vitamins /supplements
  ☐ Exercise

2 year postop:          Date:_____________
  ☐ How are you feeling?
  ☐ Expected weight loss
  ☐ Nutrition  Beverages  Food  Vitamins /supplements
  ☐ Exercise

Dietitian Visits:
  Date:_____________
  Date:_____________
  Date:_____________
  Date:_____________
  Date:_____________

Support Group:
  ______________________
  ______________________
  ______________________