VEW ASSESSMENT

Name: **Date:**

Please provide the following information in preparation for today's appointment.

Please check the box that best describes how often you vomit or regurgitate your food:

- ☐ Daily
- ☐ 2-3 times per week
- ☐ Once per week
- ☐ Once every two weeks
- ☐ Never or rarely (less than once a month)

Please check the box that best describes how long it takes you, on average, to eat a meal:

- ☐ Less than 15 minutes
- ☐ 15-30 minutes
- ☐ 30 minutes – 1 hour
- ☐ As long as it takes to finish all my food
- ☐ I tend to graze rather than eat meals

Please place a check in the column below that best describes how often you eat the following foods:

FOOD	Daily	2-3 times per week	Once per week	Monthly	Less than Monthly	Dislike/Never have eaten
Meat (Beef/Pork)						
Poultry (Chicken/Turkey)						
Fish						
Eggs						
Vegetables						
Fruit						
Bread						
Casseroles						
Pasta						
Cheese						
Yogurt/Dairy						
Rice						
Soup						
Crackers						
Chips						
Fried Foods						
Ice Cream						
Alcohol						

Please check the boxes that best describe why you stop eating:

- Due to pain or discomfort ☐
- Vomiting/Regurgitation ☐
- The plate is empty ☐
- Feeling of fullness ☐
- I'm not full but I stop myself ☐

Please check the box beside how many times you eat a day:

MEALS	SNACKS
☐ 6-7	☐ 6-7
☐ 4-5	☐ 4-5
☐ 2-3	☐ 2-3
☐ <2	☐ <2

Please check the box that best describes your current need for an adjustment:

- ☐ I need fluid removed from my band
- ☐ My band is perfect the way it is
- ☐ I need fluid added to my band

OFFICE USE ONLY:

Weight Loss – /# Of Weeks Since Last Visit- = .

V E W