Northern PSYCHIATRIC ASSOCIATES

Bariatric Questionnaire

To be completed before appointment for psychological evaluation.

Bring to your first appointment scheduled for: _____

Name:_____ Date of Birth:_____

Address: _____ City/State:_____ Zip:_____

Marital Status:_____ Race:_____ Age: _____ Telephone:_____

Name of Surgeon/Surgical Program: _____

Date(s) attended informational meeting or met with surgeon: _____

How long have you been looking into bariatric surgery?_____

What are your reasons for looking into bariatric surgery? _____

In which procedure are you interested in? (check as many as apply)

- _____ Roux-en-Y (gastric bypass)
- _____ LapBand
- _____ Duodenal Switch
- _____ VBG

What other ways have you sought information about surgery? (Please check as many as apply)

- _____ Internet
- _____ Bariatric support group meetings
- _____ Reading
- _____ TV programs
- _____ Talking with post-surgical patients
- _____ Other _____

PRIMARY HEALTHCARE PROVIDER

Physician Name: _____ Clinic: _____

Address: _____ City/State:_____ Zip:_____

Telephone: _____ How long has he/she provided care? _____

My healthcare provider:

- _____ suggested gastric surgery
- _____ supports gastric surgery
- _____ doesn't know I'm thinking about it

FAMILY HISTORY (Please circle and explain where appropriate)

Were you raised by both biological parents? YES NO If no, by whom? _____
Were your biological/adoptive parents divorced/separated? YES NO If yes, how old were you? _____
What number child were you in your family of origin? _____ Of how many children? _____
Were you raised with half siblings or step-siblings? YES NO
Were you abused/neglected in your family of origin? YES NO
Did you observe abuse of any family member in your family of origin? YES NO

Have your father, mother or siblings ever experienced any of the following problems?

Alcohol or drug abuse	YES	NO	If yes, whom? _____
Depression	YES	NO	If yes, whom? _____
Suicidal attempts	YES	NO	If yes, whom? _____
Anxiety	YES	NO	If yes, whom? _____
Mental illness	YES	NO	If yes, whom? _____
Hospitalization for emotional problems	YES	NO	If yes, whom? _____
Chronic physical illness	YES	NO	If yes, whom? _____
Incarceration (jail/prison)	YES	NO	If yes, whom? _____
Anger problems	YES	NO	If yes, whom? _____

Have you experienced the loss by death of a:

Parent:	YES	NO	If yes, whom? _____	Date: _____
Other family member	YES	NO	If yes, whom? _____	Date: _____
Close friend	YES	NO	If yes, whom? _____	Date: _____

Outside of your family of origin, have you experienced abuse? YES NO
If yes, circle type of abuse: Sexual Abuse Physical Abuse Emotional abuse/harassment

PRIMARY RELATIONSHIPS (Current or past)

Are you currently married? YES NO How long? _____ Are you living with spouse? YES NO
Are you in a committed relationship? YES NO How long? _____ Are you living with partner? YES NO
Have you been divorced? YES NO When? _____
Have you ended a committed relationship? YES NO When? _____
What is the name of your spouse/significant other? _____

CHILDREN (Include stepchildren)

	First Name	Age	Year in School/Occupation	Are they living with you now?
1.				YES NO
2.				YES NO
3.				YES NO
4.				YES NO
5.				YES NO
6.				YES NO
7.				YES NO
8.				YES NO

Do your children have any medical problems, emotional or behavioral problems? YES NO If yes, explain:

_____

_____

_____

EDUCATION

How many years of schooling have you completed? _____ Diplomas/Degrees: _____

Typical grades received: _____

What were your extracurricular activities? _____

Have you ever been diagnosed with any learning problems? YES NO

EMPLOYMENT

Are you presently employed? YES NO Occupation: _____

Are you satisfied with your present job? YES NO How long have you had your current position? _____

Do you think your employer is satisfied with your current performance? YES NO

RELIGION

Do you have a religious preference? YES NO If yes, denomination: _____

Are your spiritual beliefs an important part of your life? YES NO

LEGAL

Have you ever been arrested/incarcerated? YES NO If yes, when? _____

Why? _____

MILITARY

Were you in the military? YES NO If yes, which branch of service and when? _____

STRESSORS (Please check each way that your weight has negatively affected your daily activities)

_____ Mobility
_____ Dressing
_____ Personal hygiene
_____ Climbing stairs
_____ Recreational activities
_____ Relationships
_____ Self doubt
_____ Seating
_____ Lifting
_____ Social avoidance
_____ Exercising
_____ Increased expenses
_____ Walking and standing for extended periods
_____ Doing household chores
_____ Shopping
_____ Getting up from bed
_____ Social discrimination
_____ Job discrimination
_____ Entering and exiting an automobile
_____ Low self esteem
_____ Finding well-fitting/attractive clothing
_____ Getting out of a chair
_____ Keeping up with the children/grandchildren
_____ Sexual intimacy

Are you experiencing ***significant changes, loss, or difficulties*** in the following areas?

Financial	YES NO
Primary relationship (family/friends)	YES NO
Housing	YES NO
Physical health of self or family member	YES NO
Access to health care	YES NO
Occupational/employment	YES NO

Are you experiencing ***significant changes, loss, or difficulties*** in the following areas...*continued...*

Legal YES NO
Education YES NO
Other _____

WEIGHT/HEALTH HISTORY

Current weight: _____ Maximum lifetime weight: _____ Current height: _____
What is your goal weight? _____
At what age did you first become overweight? _____
Can you think of any reason(s) why you gained this weight? _____
_____

DIET HISTORY

Have you worked with a physician who prescribed medication for weight loss? YES NO
If yes, which ones? (Please check all that apply)
_____ Tenuate Dospan _____ Redux _____ Xenical _____ Phentermine _____ Meridia
_____ Fastin _____ Amphetamines _____ Phen-fen Other: _____

Which of the following professionals have you worked with to try to lose weight? (Please circle all that apply)
Physician Dietician Homeopath Nurse Practitioner Psychologist

Are you currently working with a dietician/physician or other professional on a weight loss program? YES NO

Listed below are many diets and methods used for weight loss. Please check all that you have tried:

_____ Acutrim
_____ Atkins
_____ Ayds
_____ Beverly Hills
_____ Cabbage soup
_____ Calorie counting
_____ Cambridge
_____ Cortislim
_____ Dexatrim
_____ Diet Center
_____ Dr. Phil
_____ Fat gram counting
_____ Grapefruit
_____ Green tea
_____ Herbal Life
_____ High protein diet
_____ Jenny Craig
_____ LA Weight Loss
_____ Low fat
_____ Mayo Clinic
_____ Medifast
_____ Metabolife
_____ Metracal
_____ New Day
_____ Nutri-Systems
_____ Optifast
_____ Overeaters Anonymous
_____ Richard Simmons
_____ Scarsdale
_____ Slim Fast
_____ South Beach
_____ Susan Powter
_____ Suzanne Sommers
_____ Sweet Success
_____ TOPS
_____ Ultra 90
_____ Weight Watchers
_____ Weigh Down
_____ Acupuncture
_____ Health club membership
_____ VCR tapes
_____ Subliminal tapes
_____ Home exercise equipment
_____ Gastric surgery
_____ Xenical

When did you first start dieting? _____

What is the most weight you have lost with a diet attempt? _____ How? _____

How long did you keep the weight off? _____

Why do you think diets are not effective for you? _____
Do you exercise on a regular basis? YES NO If yes, how? _____

What time do you typically get up in the morning? _____
List your typical breakfast in its entirety: _____

What time do you typically eat lunch? _____
List your typical lunch in its entirety: _____

What time do you typically eat dinner/supper? _____
List your typical dinner/supper in its entirety: _____

When do you snack? _____
List your typical snack(s) in their entirety: _____

Typical daily liquid intake (in ounces) Milk_____ Juice _____ Water _____ Other: _____
How much time does it take you to eat a meal? _____
In one week, how many times do you eat at a ***fast food*** restaurant? _____
In one week, how many times do you eat at ***any*** restaurant? _____
Have you ever had times when you get up in the night to eat? YES NO If yes, how often? _____
Have you ever experienced binge eating? YES NO If yes, how often? _____
Describe your binge eating: _____
Are you an emotional eater? YES NO
Have you ever made yourself vomit in order to lose weight? YES NO
Have you ever used laxatives or tried starvation as an attempt at weight loss? YES NO

Listed below are a number of medical problems. Please check all that apply and use the additional space provided to add other medical problems not listed:

_____ Diabetes
_____ Hypertension
_____ High cholesterol
_____ Fibromyalgia
_____ Chronic fatigue
_____ Arthritis
_____ COPD/emphysema
_____ Sleep apnea
_____ Irritable bowel
_____ Ulcerative colitis
_____ Spastic colon
_____ Crohn's disease
_____ Hypothyroidism
_____ Anemia

_____ Gall bladder problems
_____ Kidney problems
_____ Asthma
_____ Seasonal allergies
_____ Seizure disorder
_____ Heart disease
_____ Acid reflux
_____ Migraine headaches
_____ Varicose veins
_____ Hemorrhoids
_____ Stomach ulcer
_____ Lower leg ulcer
_____ Infertility

_____ Carpal tunnel
_____ Shortness of breath
_____ Chest pain
_____ Heavy snoring
_____ Stop breathing when asleep; awaken to catch your breath
_____ Numbness/tingling extremities
_____ Weight related joint pain, stiffness or popping

A history of:
_____ Cancer
_____ Head injury
_____ Loss of consciousness
_____ Kidney Stones
_____ Stroke
_____ Heart attack

Please list any other medical problems not shown above: _____

WOMEN ONLY

Number of pregnancies: _____ Miscarriages: _____ Abortions: _____
Post menopausal: YES NO MAYBE
My periods are: ____ regular ____ irregular ____ heavy ____ cramping ____clots

MEN ONLY

Erectile dysfunction: YES NO

SURGERIES

Listed below are a number of common surgeries. Please add the dates and outcome of the surgeries you have had. Also, please add any additional surgeries not listed below, along with the dates and outcome.

SURGERY	YEAR	OUTCOME
Appendectomy		
Gall bladder		
Tubal ligation		
Tonsillectomy		
D & C		
Bladder repair		
Oral surgery		
Hysterectomy		
Knee replacement		
Knee surgery		
Back surgery		
C-section		
Carpal tunnel		

Have you had any problems with anesthesia? YES NO Please explain: _____
Have you ever had bleeding problems? YES NO Please explain: _____
Other complications related to surgery? YES NO Please explain: _____
Have you ever had a blood transfusion? YES NO Please explain: _____
If your surgery was a tubal ligation, was it an: abdominal incision or laparoscopy (circle one)
If you surgery was a hysterectomy, was it an: abdominal incision or laparoscopy (circle one)

MEDICATIONS

Please list all current medications, including vitamins, over-the-counter, and intermittently used medications:

MEDICATION	DOSAGE	HOW OFTEN TAKEN

MEDICATION	DOSAGE	HOW OFTEN TAKEN

ALLERGIES

Are you allergic to any medicine, food, dye, tape, metal, latex, environmental, etc? YES NO
Please list specifics:

ALLERGY	REACTION

CURRENT USE OF ALCOHOL AND/OR DRUGS

Please circle your average weekly alcohol intake: None 1 – 3 drinks 4 – 8 drinks More than 8 drinks
Have you ever used mood enhancing non-prescription drugs? YES NO

Have you ever experienced any of the following?

Been picked up/charged with a drug-related driving offense	YES NO
Lost time from school or work because of drug use	YES NO
Experienced a medical problem because of drug use	YES NO
Been fired from a job because of drug use and its effects	YES NO
Felt the need to cut down on drinking or drug use	YES NO
Had people annoy you by criticizing your drinking or drug use	YES NO
Felt bad or guilty about your drinking or drug use	YES NO
Had a drink or used drugs as an eye opener first thing in the morning to steady your nerves, get rid of a hangover or get the day started	YES NO

Have you ever missed or abused prescription medications? YES NO If yes, when? _____
My average dialing nicotine use is: _____
My average daily caffeine use in the form of coffee is: _____; in the form of tea: _____;
in the form of soda pop: _____; in the form of chocolate: _____

COUNSELING HISTORY

Have you ever had counseling or mental health treatment? YES NO
Have you ever had chemical dependency treatment? YES NO
If yes, please explain why, where, when and with whom: _____
_____
_____

SYMPTOM CHECK LIST (please check the appropriate box)
How often have you been bothered by any of the following problems? Rate the following from 0 – 3 as they pertain to the last ***3 months***.

0 = No problem **1** = Mildly problematic **2** = Moderately problematic **3** = Severely problematic

SYMPTOM	0	1	2	3
1. Little interest or pleasure in doing things.				
2. Feeling down/depressed/hopeless.				
3. Trouble falling/staying asleep/sleeping too much.				
4. Feeling tired or having little energy.				
5. Poor appetite or overeating.				
6. Feeling like you are a failure or you have let yourself or others down.				
7. Trouble concentrating such as when reading or watching television.				
8. Moving or speaking so slowly that others may have noticed and mentioned.				
9. Being more fidgety or restless than usual.				
10. Thoughts that you would be better off dead/hurting yourself in some way.				
11. Trouble with every day decisions.				
12. Trouble with important decisions.				
13. Feeling guilty about things that have happened in the past.				
14. Difficulty stopping tears/crying.				
15. Engaging in one or more self-destructive activities.				
16. Thought of killing or harming another person.				
17. Hurting others with your words and/or actions.				
18. Experiencing sexual problems.				
19. Criticizing yourself and/or getting down on yourself.				
20. Going for days without sleep and feeling rested.				
21. Experiencing extreme energy changes.				
22. Experiencing panic attacks.				
23. Worrying a lot and/or unable to relax.				
24. Difficulty going places by yourself.				
25. Avoiding (non-family) social situations.				
26. Experiencing recurrent distressing dreams.				
27. Experiencing recurrent intense memories of a traumatic event.				
28. Finding it difficult to control your irritability or anger.				
29. Hearing or seeing things that others do not see or hear.				
30. Feeling that people are out to get you.				
31. Experiencing harm or harmful intentions from others.				
32. Difficulty interacting with others.				
33. Making impulsive decisions.				
34. Experiencing intense moods and mood swings.				
35. Trying to please others to the detriment of your own needs.				
36. Engaging in repetitious behaviors.				

FAMILY	IS THIS PERSON LIVING?	AGE NOW OR AT DEATH	CAUSE OF DEATH	AVG WEIGHT	HIGH BLOOD PRESS-URE	DIA-BETES	CANCER (Specify Type)	GALL BLADDER PROBLEMS	HEART PROBLEMS	STROKE	HIGH CHOLE-STEROL
Father											
Mother											
Sibling											
Sibling											
Sibling											
Sibling											
Father's Father (Grandfather)											
Father's Mother (Grandmother)											
Mother's Father (Grandfather)											
Mother's Mother (Grandmother)											
Other											