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Bariatric Surgery Psychological Evaluation Questionnaire

PLEASE USE INK!

Today's Date_____ Bariatric Surgeon_____

Name_____

Date of Birth_____Age _____Social Security#_____

Address:_____City_____ State_____ Zip Code_____

Home telephone_____ Work Phone_____ Cell Phone_____

E-mail address_____ Okay to text appointment reminders to you? Yes__No__

Marital Status_____ Number of Marriages_____

Height_____ Weight _____

Emergency contact: Name_____ Phone number_____

Information about Spouse/Partner:

Name_____

Date of Birth_____Age _____Social Security#_____

Address:_____City_____ State_____ Zip Code_____

Home telephone_____ Work Phone_____ Cell Phone_____

Years of School Completed____ Place of Employment_____

Type of Work_____ E-mail address_____

Marital Status_____ Number of Marriages_____

OTHERS IN THE HOME:

Name	**DOB**	**Age**	**Relationship**

Educational History

Years of school completed: _____

Did you have learning problems in school? Yes ___ No ____

Were you in special education? Yes ___ No ____

Did you like school? Yes ___ No ____

Please explain_____

_____

Have you attended college or a post-high school training program? Please list main schools/ programs attended and degrees or certificates earned:

_____

_____

Employment

Are you presently employed? Yes ___ No ____ Retired ____ Disabled____ Unable to find job ____

Type of work: _____

Place of Employment: _____

Favorite part of job: _____

_____

Least favorite part of job: _____

_____

Social History

In what city or cities did you grow up? _____

Was your childhood pleasant or difficult? Please briefly explain: _____

_____

Please list the names and ages of your brothers and sisters: _____

_____

How is your present relationship with your siblings? _____

Please explain: _____

_____

_____

Bariatric Surgery

Have you ever had surgery to aid in weight loss? Yes ___ No ____

If yes, please describe: _____

What type of surgery are you planning on having?
____ Sleeve ____ Lapband ____ Gastric Bypass _____

Are you familiar with the risks/benefits of each type of bariatric surgery? Yes ___ No ___

Do you know anyone that has had bariatric surgery? Yes ___ No ___

If yes, will that person be a source of support for you when you have bariatric surgery?

Yes ___ No ___

Why did you select one type of bariatric surgery over the others?

_____

_____

Approximate date you are planning to have bariatric surgery _____

On a scale of one to ten, with ten being highest, what is your level of anxiety about having bariatric surgery?
1 2 3 4 5 6 7 8 9 10

Have you talked with your spouse/partner, adult children, and/or close friends about your plans to have bariatric surgery? Yes ____ No ____
If yes, how have they responded?

_____

_____

Mental Health History
Please check any of the following problems that you are have experienced in your life:

___ Depression ____ Anxiety ___ Hallucinations ____ Manic Episodes ___ Childhood Physical Abuse ___ Childhood Sexual Abuse ___ Childhood Neglect ___ Spouse Abuse ___ Adult Sexual Assault ___ Adult Physical Abuse/Assault ___Suicide Attempt

If you have ever had a Suicide attempt, please describe:

Other traumatic experiences. Describe: _____

Have you ever been in counseling? Yes ___ No ___
If yes: When_____ With Whom_____

Did you find the counseling helpful? Yes ___ No ___

Have you ever been referred to a psychiatrist or your family doctor for an evaluation for medication? _____

Emotional/Social Life

On a scale of 1 to 5 (1 being least happy and 5 being most happy) circle your answers to the following:

How happy are you in your present marriage/relationship? 1 2 3 4 5 N/A

How happy are you with your present job? 1 2 3 4 5 N/A

How would you rate your overall satisfaction with yourself? 1 2 3 4 5

Reasons you are not satisfied with yourself?

Circle any of the following words that apply to you:

Worthless, useless, a "nobody", "life is empty", inadequate, stupid, incompetent, naïve, "can't do anything right", guilty, evil, morally wrong, horrible thoughts, hostile, full of hate, anxious, agitated, cowardly, unassertive, panicky, aggressive, ugly, deformed, unattractive, repulsive, depressed, lonely, unloved, misunderstood, bored, restless, confused, unconfident, in conflict, full of regrets, worthwhile, sympathetic, intelligent, attractive, confident, considerate, friendly, isolated, nightmares, feel tense, shy , exhausted, panicky, memory problems, sexual problems, tense.

If you had three wishes today, what would they be?

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Medical History

	Present	Past	Uncertain	None	Family hx
NEUROLOGICAL					
Headaches	☐	☐	☐	☐	☐
Dizziness	☐	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐	☐
Blackouts	☐	☐	☐	☐	☐
Head injury	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Convulsions/ seizures	☐	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐	☐
ADDICTIONS					
Alcohol	☐	☐	☐	☐	☐
Drugs	☐	☐	☐	☐	☐
Nicotine	☐	☐	☐	☐	☐
Caffeine	☐	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐	☐
PULMONARY/LUNGS					
Asthma	☐	☐	☐	☐	☐
Bronchitis	☐	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐	☐
Pneumonia	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐
Sleep apnea	☐	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐	☐
DIGESTIVE (GI)					
Stomach/duodenal ulcer	☐	☐	☐	☐	☐
Nausea or vomiting	☐	☐	☐	☐	☐
Weight loss and/or gain	☐	☐	☐	☐	☐
Diverticulosis	☐	☐	☐	☐	☐
Colitis	☐	☐	☐	☐	☐
Blood in stools	☐	☐	☐	☐	☐
Constipation or diarrhea	☐	☐	☐	☐	☐
Dental/oral problem	☐	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐	☐
REPRODUCTIVE					
Hemorrhoids	☐	☐	☐	☐	☐
Prostate problem (males	☐	☐	☐	☐	☐
Gynecologic problem (females)	☐	☐	☐	☐	☐
Venereal disease	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐
HEMATOLOGIC					
Anemia	☐	☐	☐	☐	☐
Bleeding	☐	☐	☐	☐	☐
Genital herpes	☐	☐	☐	☐	☐
Liver problems	☐	☐	☐	☐	☐
Gallbladder problems	☐	☐	☐	☐	☐
Hernia	☐	☐	☐	☐	☐
Breast disease	☐	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐	☐
CARDIOVASCULAR					
High blood pressure	☐	☐	☐	☐	☐
Low blood pressure	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐
Arteriosclerosis (hardening of arteries)	☐	☐	☐	☐	☐
Heart attack	☐	☐	☐	☐	☐
Chest pain	☐	☐	☐	☐	☐
Irregular heartbeat	☐	☐	☐	☐	☐
Heart murmur	☐	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐	☐
EYE/EARS/NOSE/THROAT					
Eye or eyelid infection	☐	☐	☐	☐	☐
Other eye problems	☐	☐	☐	☐	☐
Ear infection	☐	☐	☐	☐	☐
Deafness or decreased hearing	☐	☐	☐	☐	☐
Allergies or hay fever	☐	☐	☐	☐	☐
Frequent nosebleeds	☐	☐	☐	☐	☐
Difficulty swallowing	☐	☐	☐	☐	☐
Strep throat	☐	☐	☐	☐	☐
KIDNEY/RENAL					
Kidney or bladder disease	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐
ENDOCRINE/META					
Thyroid problems	☐	☐	☐	☐	☐
Diabetes (Type I)	☐	☐	☐	☐	☐
Diabetes (Type II)	☐	☐	☐	☐	☐
Lupus	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐

IMMUNE SYSTEM

Food allergies	☐	☐	☐	☐	☐
Other allergies, excluding ENT	☐	☐	☐	☐	☐
Tumor(s), cancerous or benign	☐	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐	☐

INFECTIONS

Measles	☐	☐	☐	☐	☐
German measles/Rubella	☐	☐	☐	☐	☐
Polio	☐	☐	☐	☐	☐
Mumps	☐	☐	☐	☐	☐
Scarlet fever	☐	☐	☐	☐	☐
Chicken pox	☐	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐	☐
Mononucleosis	☐	☐	☐	☐	☐
Open wound(s)	☐	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐	☐

MUSCULOSKELETAL

Arthritis/Rheumatoid arthritis	☐	☐	☐	☐	☐
Gout	☐	☐	☐	☐	☐
Muscle weakness	☐	☐	☐	☐	☐
Muscle pain	☐	☐	☐	☐	☐
Bone fracture	☐	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐	☐

DERMATOLOGIC/SKIN

Eczema	☐	☐	☐	☐	☐
Psoriasis	☐	☐	☐	☐	☐
Skin rash	☐	☐	☐	☐	☐

CURRENT HEALTH HABITS

	Yes	No
Daily aerobic exercise	☐	☐
Stable weight	☐	☐
Stable sleep	☐	☐
Coping skills for stress	☐	☐
Wake up rested most mornings	☐	☐
Have someone to turn to when troubled or upset	☐	☐

PERSONAL PHYSICIAN (Name, phone, address): _____

_____

Date of last physical exam: _____ Date of latest blood tests: _____

ALLERGIES: Do you have any allergies to medications? ☐ Yes ☐ No

If yes, to which ones? _____

To Foods? ☐ Yes ☐ No If yes, to which ones?

Please list all medications (include over-the-counter) and their doses that you are currently taking:

MEDICATION	DOSE	MEDICATION	DOSE

History of hospitalizations, surgeries, and all other inpatient or outpatient procedures

_____

_____

_____

_____

_____

_____

_____

_____ Please list and discuss all medical conditions that are not under good control:

_____

_____

_____

_____

WEIGHT HISTORY

How long have you been at your current weight? _____
Your weight at Birth _____ At 10- years old _____
At 14 years old _____ At 18 years old _____
What is the most you have ever weighed? _____ How old were you at the time? _____

What factors have caused your weight problem? Please check all that apply.

____	Eat too much food	____	Snack too much
____	Eat foods those are too high in fat	____	Eat foods that have too much sugar
____	Binge eat (eat until overly full)	____	Eat when stressed/bored/depressed
____	Family History of obesity	____	Unresolved emotional trauma
____	Slow Metabolism	____	Health problems

Other (please specify) _____

_____

Diet History

Have you tried diet pills? Yes ___No ___

If yes, what kind:_____

Have you ever used laxatives to lose weight? Yes ___No ___
If yes, please describe: _____

_____

Have you ever taken diuretics ("water pills") to lose weight? Yes ___No ___
If yes, please describe: _____

_____

What diets have you tried to lose weight? _____

_____

What was your most successful weight loss program? _____

_____

How much weight did you lose and why did this work for you? _____

_____

Approximate date of weight loss: _____

How long did you maintain the weight loss? _____

What are your favorite foods? _____

What are your favorite snacks? _____

Exercise History

Do you exercise regularly (3 or more time/week)? Yes ___ No ___

If no, why not? ___ Joint pain ___ Shortness of breath ___ Dislike exercise

Other, please explain: _____

If you do exercise regularly, what do you do? _____

How often do you exercise? _____

Substance Use/Abuse

Have you ever used tobacco products in the past? Yes ___ No ___
What type: Smoke __ Smokeless ___

If yes, how many (cigarettes, cigars, pipes) per day? _____ For how long? _____

When did you quit smoking? _____ I have not quit yet. _____

Do you drink alcohol currently? Yes ___ No ___

If yes, what beverages? _____

How many drinks per day? _____

Do you take tranquilizers? Yes ___ No ___ If yes, how often? _____

Do you need sleeping pills to sleep? Yes ___ No ___

If yes, what do you take?
_____

Have you ever used recreational or street drugs? Yes ___ No ___

If yes, what and when? _____

When did you quit?_____ I have not quit yet ____

Have you ever taken more than the prescribed dosage of medications? Yes ___ No ___

Did you become addicted? Yes ___ No ___

If yes, what and when? _____

When did you quit? _____ I have not quit yet _____

Do you consume caffeine (e.g., coffee, sodas, energy drinks)? Yes ___ No ___

Describe type and typical use per day _____

_____

Have you ever felt that you should cut down on your drinking/drug use? Yes ___ No ___

Has anyone annoyed you by telling you to cut down on your drinking/drug use? Yes __ No __

Have you ever felt guilty or bad about your drinking/drug use? Yes ___ No ___

Do you ever wake up in the morning wanting to have an alcoholic drink or take drugs (eye opener?) Yes ___ No ___

Has anyone ever criticized you or told you that you have a gambling problem? Yes ___ No ___

Have you ever had to lie to family members, friends, or therapists about your gambling practices? Yes ___ No ___

Well Being Questionnaire

Directions: Please circle any of the following that apply to yon:

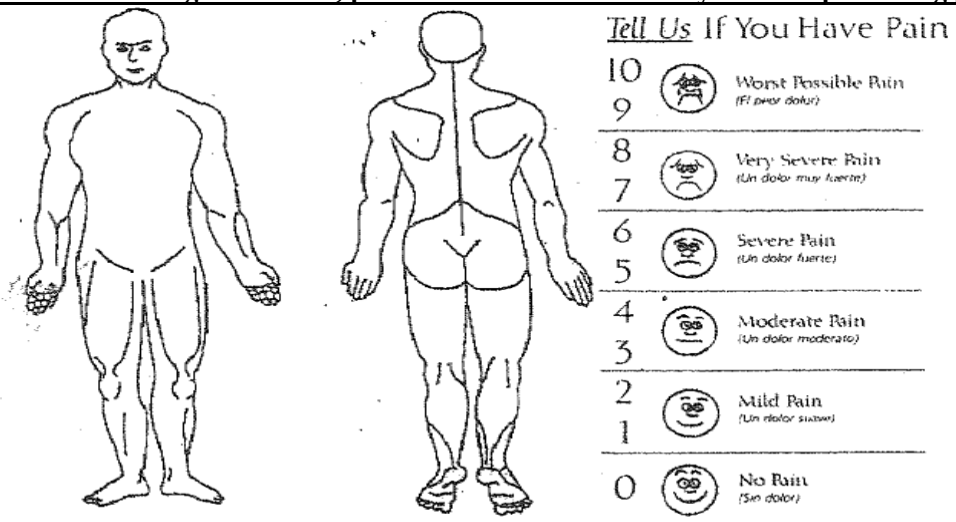
Blurred vision Dry mouth Excess saliva Difficulty swallowing Dizziness Memory problems Restless Too happy Oversensitive to criticism Living dangerously (spending, gambling, speeding) Impulsive Racing thoughts Seeing or hearing things that are not there Constipation Diarrhea Hyper-feeling Difficulty breathing Weird thoughts Violent thoughts Trouble falling asleep Trouble staying asleep Early morning awakening Frequent troubling nightmares Vivid dreaming

If you had three wishes, what would they be?

1. _____
2. _____
3. _____

PAIN SURVEY IF APPLICABLE

Directions: On the diagrams below, please mark the areas where you are experiencing pain:



OBESITY RELATED HEALTH PROBLEMS

Obstructive Sleep Apnea

In what position do you sleep? Sitting up ___ Lying flat on my back ___
Lying on my side ___ Lying on my stomach___

How many pillows do you use under your head? _____

Do you awaken from sleep to catch your breath? Yes ___ No ___

If yes, how often? _____

Do you snore? Yes ___ No ___

Do you sometimes stop breathing while you are asleep? Yes ___ No ___

Do you occasionally doze off while you are talking to someone? Yes ___ No ___

Have you ever had an evaluation for sleep apnea (i.e. a sleep study)? Yes ___ No ___

If yes, when and where? _____

What were the results? _____

Shortness of Breath/Pulmonary
Do you experience shortness of breath with physical activity? Yes ___ No ___

How long have you been aware of this (be specific)? _____Years _____Months
When walking upstairs, how many steps can you climb before noticing shortness of breath?
_____Steps _____Flights

When do you have to stop and rest? After _____ Steps **OR** After _____ Flights

Other-Related Health Problems
Do you experience swelling of your ankles? Yes ___ No ____

If yes, how long? _____

What do you do to decrease the swelling in your ankles?
_____

_____

Do you experience chest pain? Yes ___ No ___ How long? _____

Do your parents or siblings have weight problems? Yes ___ No ___

If yes, please describe _____

_____

Do you experience chronic heartburn? Yes ___ No ___

If Yes, what is the cause? _____

SOCIAL SUPPORT: Do you have a good social support network with friends? Yes ___ No ____

Do you feel emotionally supported by family members? Yes ____ No ____

Do you have spiritual beliefs that are helpful to you when stressed, upset or facing a challenge?
Yes ___ No ___

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CIRCLE THE APPROPRIATE ANSWER

	Never	Rarely	Some-times	Frequ-ently	Almost Always	SD	IR	SR
1. I get along with others.	4	3	2	1	0	✚		✚
2. I tire quickly.	0	1	2	3	4		✚	✚
3. I feel no interest in things.	0	1	2	3	4		✚	✚
4. I feel stressed at work/school/housework/volunteering.	0	1	2	3	4	✚	✚	
5. I blame myself for things.	0	1	2	3	4		✚	✚
6. I feel irritated.	0	1	2	3	4		✚	✚
7. I feel unhappy in my marriage/significant relationship.	0	1	2	3	4	✚		✚
8. I have thoughts of ending my life.	0	1	2	3	4		✚	✚
9. I feel weak.	0	1	2	3	4		✚	✚
10. I feel fearful.	0	1	2	3	4		✚	✚
11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark "never")	0	1	2	3	4		✚	✚
12. I find my work/school/ housework/volunteering satisfying.	4	3	2	1	0	✚	✚	
13. I am a happy person.	4	3	2	1	0		✚	✚
14. I work/study too much.	0	1	2	3	4	✚	✚	
15. I feel worthless	0	1	2	3	4		✚	✚
16. I am concerned about family troubles.	0	1	2	3	4	✚		✚
17. I have an unfulfilling sex life.	0	1	2	3	4	✚		✚
18. I feel lonely.	0	1	2	3	4	✚		✚
19. I have frequent arguments.	0	1	2	3	4	✚		✚
20. I feel loved and wanted.	4	3	2	1	0	✚		✚
21. I enjoy my spare time.	4	3	2	1	0	✚	✚	
22. I have difficulty concentrating.	0	1	2	3	4		✚	✚
23. I feel hopeless about the future.	0	1	2	3	4		✚	✚
24. I like myself.	4	3	2	1	0		✚	✚
25. Disturbing thoughts come into my mind that I can't get rid of.	0	1	2	3	4		✚	✚
26. I feel annoyed by people who criticize my drinking (or frequent drug use). (If not applicable, mark "never")	0	1	2	3	4	✚		✚
27. I have an upset stomach.	0	1	2	3	4		✚	✚
28. I am not working/studying housework/volunteering as well as I used to.	0	1	2	3	4	✚	✚	
29. My heart pounds too much.	0	1	2	3	4		✚	✚
30. I have trouble getting along with my friends and close acquaintances.	0	1	2	3	4	✚		✚
31. I am satisfied with my life.	4	3	2	1	0		✚	✚
32. I have trouble at work/school housework/volunteering because of drinking or drug use. (If not applicable, mark "never")	0	1	2	3	4	✚	✚	
33. I feel that something bad is going to happen.	0	1	2	3	4		✚	✚
34. I have sore muscles.	0	1	2	3	4		✚	✚
35. I feel afraid of open spaces, or driving, or being on buses, subways, and so forth.	0	1	2	3	4		✚	✚
36. I feel nervous.	0	1	2	3	4		✚	✚
37. I feel my love relationships are full and complete.	4	3	2	1	0	✚		✚
38. I feel that I am not doing well at work/school.	0	1	2	3	4	✚	✚	
39. I have too many disagreements at work/school.	0	1	2	3	4	✚	✚	
40. I feel something is wrong with my mind.	0	1	2	3	4		✚	✚
41. I have trouble falling asleep or staying asleep.	0	1	2	3	4		✚	✚
42. I feel blue.	0	1	2	3	4		✚	✚
43. I am satisfied with my relationships with others.	4	3	2	1	0	✚		✚
44. I feel angry enough at work/school housework/volunteering to do something I may regret.	0	1	2	3	4	✚	✚	
45. I have headaches.	0	1	2	3	4		✚	✚
46. I feel restless & can't sit still.	0	1	2	3	4	✚	✚	✚
47. I hear or see things that may not be there.	0	1	2	3	4	✚	✚	✚
48. I do impulsive things (spending/gambling/dangerous driving)	0	1	2	3	4	✚	✚	✚
49. My thoughts race.	0	1	2	3	4	✚	✚	✚
					TOTAL:			

Even though we will ask to make a copy of your insurance card, we would appreciate if you would fill in the following information:

PRIMARY INSURANCE COMPANY

Name of Insurance Company_____ Policy#_____ Group#_____
Claims Address of Insurance Company_____
Name of Insured Person_____ DOB _____ Social Security#_____
Address, Phone Numbers and Place of Employment for Insured (if different from first page):
Address:_____City_____ State_____ Zip Code_____
Home telephone_____ Cell Phone_____
Place of Employment_____ Work Phone_____

SECONDARY INSURANCE COMPANY

Name of Insurance Company_____ Policy#_____ Group#_____
Claims Address of Insurance Company_____
Name of Insured Person_____ DOB _____ Social Security#_____
Address, Phone Numbers and Place of Employment for Insured (if different from first page):
Address:_____City_____ State_____ Zip Code_____
Home telephone_____ Cell Phone_____
Place of Employment_____ Work Phone_____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process insurance claims: Yes ___ No ___

I authorize payment of medical benefits for services rendered: Yes ___ No ___

SIGNED: _____DATE:_____

***Informed Consent*:**

I understand that the surgeon performing the bariatric surgery and/or my insurance company in making the final determination regarding the approval for me to undergo the surgery will use the results of this psychological evaluation. I also understand that the psychologist who performs the evaluation is not the person who makes the final decision about whether I have given approval, but, rather, is making recommendations to the surgeon and the insurance company via his or her report.

***Patient Signature* _____ *Date* _____**

Signature/Release

I authorize the evaluating psychologist to contact my mental health counselor, _____, to consult him/her regarding this psychological evaluation for bariatric surgery.
Yes ___ No ___ Not Applicable ___

I authorize the evaluating psychologist to release my psychological evaluation for bariatric surgery to _____, my bariatric surgeon.
Yes ___ No ___

***Patient Signature* _____ *Date* _____**