HELFMAN
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Cultivating Possibilities

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PRE-BARIATRIC SURGERY QUESTIONNAIRE

Your pre-surgical evaluation is intended to help you and your surgeon to better understand how to assist you in ensuring the best possible results from surgery. It will also serve as a tool to discuss surgery and its risks, the lifestyle changes you will have to make, and what you can expect after surgery so that you can formulate the best choice for you. Your full cooperation and honesty in this evaluation will help you achieve these aims. You should also know that denying a patient surgery is quite rare.

Your Name: _____

What is your *current* weight? _____

What is your height? _____ft _____ inches

What is your *highest weight ever* as an adult (excluding pregnancy)? _____

What age were you when you reached your highest weight ever? _____

What is your lowest weight ever as an adult? _____

What age were you when you reached your lowest weight ever? _____

After surgery, what is your goal weight range? _____

Your Surgeon's Name and Address: _____

_____

Surgeon's phone number: (____)_____

How many times have you met with your surgeon? _____
Have you met with a dietitian regarding surgery? _____
When is your next appointment with your surgeon? _____

What kind of bariatric surgery are you considering or planning to have? (Check one)

☐ Roux-en-Y ☐ Biliopancreatic Diversion ☐ Sleeve Gastrectomy
☐ Lap Band ☐ Have not decided ☐ Other

When do you expect to have your surgery? _____

Who is your primary care physician? _____

What medication(s) and dosages are you *currently* taking? _____

_____

_____

Are you *currently* in therapy for depression, anxiety, or any other emotional issues?

☐ No ☐ Yes

What are the name, location, and phone number for your current therapist? _____

_____

Do I have your permission to exchange information with your current therapist?

☐ Yes ☐ No

What medication(s) have you been prescribed *both **now** and in the **past*** for emotional issues? _____

_____

What are the current stressors in your life? (Check all that apply)

☐ Financial ☐ Work-related stress ☐ Relationships
☐ Marital stress ☐ Caring for older parents ☐ Caring for children
☐ Health ☐ Depression ☐ Moodiness
☐ Substance/alcohol use ☐ Family stress
☐ Other stressors? Explain: _____

_____

Have you ever *thought* about attempting suicide?

☐ No ☐ Yes If *yes*, when and why? _____

_____

Have you ever *actually tried* to commit suicide?

☐ No ☐ Yes If *yes*, how many times? _____

When and why? _____

_____

What was the outcome? (e.g., ended up in hospital, saw a therapist, etc.) _____

_____

Have you ever been *hospitalized* for depression, suicidal ideation, a suicide attempt, or any other emotional problem?
☐ No ☐ Yes

If "yes", when and where? _____

Have any of your family members been diagnosed with a psychiatric condition?
☐ No ☐ Yes If *yes*, please explain _____

_____

Do you feel that you *lose control* over eating or can't stop eating at times?
☐ No ☐ Yes

If *yes*, about how often on average? (Check one)
☐ Twice a week or more ☐ Less than twice a week

How would you describe your eating? (Check all that apply)
☐ I graze or nibble throughout the day
☐ I overeat at meals
☐ I overeat just at dinner
☐ I mostly snack and overeat in the evenings, after dinnertime
☐ Sometimes I get up during the night and eat
☐ I am an emotional eater (e.g., because of boredom, sadness, anger, anxiety, etc.)
☐ I often lose control and eat a lot at one time
☐ I am a compulsive overeater
☐ I crave sugar or other foods
☐ I often overeat just because food is there
☐ I sometimes sneak food or hide it
☐ I don't like to eat in front of others
☐ Other Please describe: _____

Over the *past year*, how would you describe your activity level?
☐ Sedentary ☐ Somewhat active ☐ Moderately active ☐ Regularly active

Over the ***past year***, describe what kind of exercise you have engaged in and about how often? _____

In the ***past two weeks***, what exercise have you engaged in and how often? _____

_____

What medical problems do you suffer as a result of obesity? (Check all that apply)

☐ Sleep apnea ☐ Skin rashes ☐ Asthma ☐ Joint Problems
☐ Difficulty moving ☐ High Blood Pressure ☐ Knee, back, or hip pain
☐ High cholesterol ☐ Diabetes
☐ Acid reflux or heartburn ☐ Other. Please describe: _____

_____

Have you ever had any of the following eating disorders or disordered eating patterns? (Check all that apply)

☐ Anorexia (self-starvation to lose weight)
☐ Bulimia (bingeing and vomiting)
☐ Chewing food and spitting it out
☐ Binge Eating Disorder (eating large quantities of food without compensating for calories consumed by vomiting, exercise, using laxatives, etc.)

What programs or methods have you tried to lose weight? (Check all that apply)

☐ Weight Watchers ☐ Jenny Craig ☐ Overeaters Anonymous
☐ Nutrisystem ☐ Prescription Diet pills ☐ Exercise
☐ Shots from physician ☐ Dieting
☐ Dietitian or nutritionist ☐ Other. Describe: _____

_____

What is that maximum amount of weight that you have ever lost on any program or method? _____

How many years or months ago? _____

How long did you maintain the weight loss: _____

Please describe your alcohol use *on average over the last 6 months*. (Choose one.)

☐ Drink more than two drinks per day ☐ Drink one drink per day
☐ Drink about once a week ☐ Drink about once a month
☐ Don't drink ☐ Drink only socially, usually about one drink
How often? _____

Have you ever been told that you have a problem with drinking? ☐ No ☐ Yes

Have you ever been told that you have a problem with substances? ☐ No ☐ Yes

Now, before surgery, how does your support group (spouse, family, or friends) feel about your having surgery?

☐ Very Supportive ☐ Somewhat Supportive ☐ Not Supportive

Comment further on your support: _____

Who can you count on to be your support system after surgery?

☐ Spouse or significant other ☐ Children ☐ Parents ☐ Extended Family
☐ One or more friends ☐ Surgery support group groups
☐ Therapist ☐ Dietitian ☐ Other: Indicate who? _____

_____

Why have you decided to seek bariatric surgery at this time? _____

_____

How do you think bariatric surgery will change your life? _____

_____

_____

_____

What are your hopes and expectations for what surgery will do for you?_____

_____

_____

Please comment on what else you think I should know in order to make a bariatric surgery evaluation for you: _____

_____

_____

_____

_____ _____

Patient Signature Date