PSYCHOSOCIAL BACKGROUND QUESTIONNAIRE FOR BARIATRIC SURGERY

Please complete the following information as honestly as possible and add additional information which you believe will be helpful. This information will assist us in determining what additional questions we may need to ask about your life history to determine your appropriateness for surgery for obesity.

Name: ______________________________________ Date: __________________________________

Age:_____ Male____ or Female ____ Date of Birth: ________/____/___________

Telephone:_____________________________ Email:________________________________
(best # to reach you at between 8 a.m. – 6 p.m.)

Ethnic Background:

- ❑ African American
- ❑ Asian American
- ❑ Native American
- ❑ Other:__________________
- ❑ European American
- ❑ Hispanic American

Marital Status:

- ❑ Never Married
- ❑ Married (first marriage)
- ❑ Married (previously divorced or widowed)
- ❑ Living with partner
- ❑ Not Married but in a committed relationship (not living together)
- ❑ Divorced (not presently married)
- ❑ Widowed (not presently married)

Highest Level of Education:

- ❑ 8th Grade or less
- ❑ Some high school
- ❑ High school graduate
- ❑ Trade or technical school
- ❑ Some college
- ❑ College graduate
- ❑ Some graduate study
- ❑ Post-graduate degree
- ❑ M.A./M.S./M.Ed.
- ❑ Ph.D./Psy.D./Ed.D./Pharm.D.
- ❑ M.D./ D.O.
- ❑ Other:________________

Current Occupation:____

Length of time at current employer:____

Surgeon: □ Dr. Wohlgemuth □ Dr. Fontana □ Dr. Brooks □ Dr. Boustany □ Other:

Type of surgery: □ Gastric Bypass □ Gastric Sleeve □ Gastric Band (Lap Band)

Current Height: _____________ Highest Adult Weight:_____________

Current Weight: _____________ Lowest Adult Weight: _____________

What is your goal weight after the surgery? _____________

How long have you been considering weight-loss surgery? _______________________________

What is your main reason for pursing weight loss surgery? (Circle all that apply)

Health Reasons Improve quality of life

Appearance Frustrated with other failed weight loss attempts

Other: ____

Why did you choose the type of surgery you did (i.e., Lap-band or Gastric Bypass)?

Were you overweight

as an infant?	Yes	No	as a child?	Yes	No
as a teenager?	Yes	No	as a young adult?	Yes	No

At what age do you first recall recognizing that you struggled with keeping off weight? _______

What do you believe are the contributing factors to your struggle with weight?

Genetics Inconsistency

Poor Eating Habits Sedentary Lifestyle

Injury or Illness Emotional Eating/Overeating

Other: ____

At what age did you begin to diet, or attempt to control your weight? ________________

Previous Weight Loss Attempts. Please list specific diet names, exercise programs, nutritionist, medications, over-the-counter pills, etc.), and how much weight did you lose on each of these attempts:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

7. ____

8. ____

9. ____

10. ____

Why have you been unable to continue with most weight loss programs? (Circle all that apply)

Too restrictive	Frustrated with slow results
Lifestyle changes	Bored with plan
Inconsistency	Special Event (e.g., holiday, vacation, etc.)

Other:

Do your family members know about your weight problems and choice to seek surgery? Yes No

If yes, do they support your decision to consider surgery? Yes No

Notes:

Do you feel that your weight contributes to problems in social or professional areas? Yes No

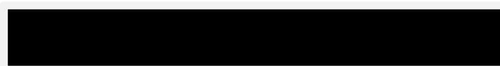
Please Explain:

Please briefly describe what you do on a typical weekday, starting with the time you wake up in the morning, and ending with the time you go to bed at night?

Please describe any restrictions on your activities you believe are caused by your weight?

Do you believe that your relationships are affected by your weight? Yes No

If so, how?



Are you currently following a weight loss plan? Yes No

If yes, what are using at this time to attempt to control your weight? __________________

____

If no, what changes are you making to prepare yourself for the surgery? _______________

____

How many meals do you eat per day (on average)? ___________

Are you familiar with counting calories? Yes No

How many calories would you estimate that you eat per day (on average)? ___________

Who does most of the grocery shopping for your household?

Who does most of the cooking for your household?

Do you currently exercise? Yes No

If yes, what type of exercise and how often? _______________________________________

If no, why? ____

What is your plan for exercise following the surgery?

Why do you think surgery will be more successful for you than the other weight control measures you have tried in the past?

Circle all of the types of foods/rules that you know are required of you following surgery:

- Multiple meals a day
- Reduced sugar/carbohydrate Intake
- Reduced intake of fat
- Food Journaling
- Follow up with physician
- No drinking during meals
- No carbonated beverages
- Exercise
- Weighing yourself weekly
- Support Groups

Given what you currently know about the plan you will be following after surgery; which part do you think will be the most difficult for you?

What changes are you making to ease your transition following surgery? (Circle all that apply)

Increasing meals and decreasing portions	Increasing water intake
Increasing Exercise	Vitamins
Changes to diet (e.g., no carbonation, etc.)	Other: ________________________

Who do you live with? ____

____

Are the individuals in your household supportive of this surgery? Yes No

If no, please explain:

Are there *other* individuals in your life that know about the surgery and will offer you support (e.g., friends, co-workers, relatives, etc.)?

Do you know other individuals who have undergone weight loss surgery? Yes No
If yes, tell me what you have learned from these individuals:

Please describe the major stressors in your life at this time, and how you generally cope with them (e.g., family stressors, work, financial, weight, etc.):

<u>Mental Health History</u>

Have you ever been hospitalized for a psychological difficulty? □ Yes □ No
If the answer is yes: Date(s): ____

Facility: ____

Reason: ____

Have you ever had mental health/family/marriage counseling? □ Yes □ No
If the answer is yes: Date(s): ____

Counselor(s): ____

Have you ever been under the care of a psychiatrist? □ Yes □ No

If the answer is yes: Date(s): ______________________________________

Psychiatrist: ____

Medications Prescribed: ____

Have you ever thought a lot about trying to harm or kill yourself? □ Yes □ No

If the answer is yes: When: ____

Where: ____

Have you ever tried to harm or kill yourself? □ Yes □ No

If the answer is yes: When: ____

Where: ____

Please mark all of the items below that apply, and add any others at the bottom of the next page under "Additional concerns or issues."

Mood

- ❑ Anger, hostility, arguing, irritability
- ❑ Aggression, violence
- ❑ Nervousness, panic/anxiety attacks
- ❑ Crying spells
- ❑ Depression, low mood, sadness
- ❑ Emptiness
- ❑ Failure
- ❑ Fatigue, tiredness, low energy
- ❑ Fears, phobias
- ❑ Grieving deaths, losses, divorce
- ❑ Guilt
- ❑ Hopelessness
- ❑ Loss of control, outbursts
- ❑ Inferiority
- ❑ Loneliness
- ❑ Low self-esteem
- ❑ Mood swings
- ❑ Nervousness, tension
- ❑ Pessimism
- ❑ Shyness
- ❑ Stress, tension
- ❑ Suspiciousness
- ❑ Suicidal thoughts
- ❑ Withdrawal, isolating

Relationship Problems

- ❑ Children, child management, child care, parenting
- ❑ Childhood issues (own childhood)
- ❑ Child custody/visitation
- ❑ Dependence
- ❑ Marital conflict, infidelity/affairs

- ❑ Sexual issues, dysfunctions, desire, differences, etc.
- ❑ Family conflict
- ❑ Friendships
- ❑ Interpersonal conflicts
- ❑ Divorce, separation
- ❑ Sexual compulsivity

Health Problems & Concerns

- ❑ Overeating
- ❑ Under-eating/food restriction
- ❑ Binging
- ❑ Vomiting
- ❑ Illness/injury
- ❑ Medical concerns
- ❑ Physical problems
- ❑ Headaches
- ❑ Menstrual problems
- ❑ PMS
- ❑ Menopause
- ❑ Self-neglect, poor self-care
- ❑ Sleep too much
- ❑ Sleep too little
- ❑ Insomnia
- ❑ Nightmares

Problems with Thinking

- ❑ Attention, concentration, distractibility
- ❑ Decision making, indecision, mixed feelings, putting off decisions
- ❑ Obsessions, compulsions, (thoughts or actions that repeat)
- ❑ Delusions (false ideas)
- ❑ Memory problems
- ❑ Confusion

Abuse

- ❑ Physical
- ❑ Sexual
- ❑ Emotional
- ❑ Neglect (of a child or elderly)

Employment/Career Problems

- ❑ Career goals
- ❑ Career choices
- ❑ Over-working
- ❑ Problems with co-workers
- ❑ Unemployment
- ❑ Can’t keep a job

Financial/Legal Problems

- ❑ Bankruptcy
- ❑ Consumer debt
- ❑ Impulsive spending
- ❑ Low income
- ❑ Gambling
- ❑ Arrest
- ❑ Lawsuit
- ❑ DWI/DUI

Other Problems

- ❑ Over sensitivity to rejections
- ❑ Perfectionism
- ❑ Procrastination
- ❑ Self-centeredness
- ❑ Low motivation, laziness
- ❑ Judgment problems, risk taking
- ❑ Irresponsibility

Additional concerns or issues: ____
____

Do you have a family history of mental health treatment? Yes No
If yes, which family member and what are/were they treated for (depression, anxiety, AD/HD, etc.)?

When was your last MEDICAL checkup? (MM/DD/YY) _____/_____/_____

MEDICAL PROBLEMS:

- ❑ Allergies
- ❑ Anemia
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Problems
- ❑ Cataracts
- ❑ Cancer/Leukemia
- ❑ Cholesterol
- ❑ Colitis
- ❑ COPD
- ❑ Depression
- ❑ Diabetes
- ❑ Epilepsy/Seizures
- ❑ Eczema
- ❑ Erectile Dysfunction
- ❑ Gall Bladder
- ❑ Glandular Diseases
- ❑ Gout
- ❑ Head Injury
- ❑ Heart Disease
- ❑ Heartburn/Reflux
- ❑ Hypertension
- ❑ Liver Cirrhosis
- ❑ Kidney Disease
- ❑ Migraines
- ❑ Morbid Obesity
- ❑ Muscle/Joint Pain
- ❑ Nerve Disease
- ❑ Non-Alcoholic Fatty Liver
- ❑ Polycystic Ovarian Syndrome
- ❑ Thyroid Problems
- ❑ Seizures
- ❑ Sleep Apnea
- ❑ Strokes
- ❑ Ulcers
- ❑ Other: ___________

Please list any **surgeries** or a **serious accidents** below.:

What type of surgery or accident happened?	When?	Are you having current problems because of it? If so, what?

Please use the back of this paper if you need additional space.

Do you have any medicine/food allergies? Yes No If yes, please explain:

Please list your **current medications** (prescribed, OTC, & vitamins/minerals /herbal supplements):

Name of Medication	Dosage	Why do you take it?	Who prescribes it?

Please use the back of this paper if you need additional space.

Please indicate below your current and past alcohol and/or drug use by placing either a Y= Yes or N = No in 1st and 3rd columns.

Type of Substance	Do you use it now?	If current use, how much? D = Daily; W = Weekly; M = Monthly	Have you used it in the past?	If no current use, but used in the past please indicated highest level of use and when it was? D = Daily; W = Weekly; M = Monthly
Alcohol				
Tobacco				
Marijuana				
Cocaine				
Heroin				
Stimulants (e.g. Speed)				
Hallucinogens (e.g. LSD)				
PCP				
Inhalants				

Pain meds (e.g., Percocet)				
Other:				

If you responded with a Y = Yes to any of the above substances, please answer the following questions.

Is use of this substance(s) currently a problem for you?	Yes	No	N/A
Do others think this is a problem?	Yes	No	N/A
Was use of this substance(s) a problem to you in the past?	Yes	No	N/A
Did others think it was a problem?	Yes	No	N/A

Have you ever required **treatment for substance use**? If so, please complete the following table:

Year	Treating Clinician or Facility	Substance issue treated	Treatment received (describe)	Helpful? (Y or N)
			❑ Outpatient ❑ Inpatient	
			❑ Outpatient ❑ Inpatient	
			❑ Outpatient ❑ Inpatient	

Thank you for taking the time to fill out this evaluation!