

BARIATRIC SURGERY SCREENING QUESTIONNAIRE
HEALTH PSYCHOLOGY CLINIC

NAME _____ DATE _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE _____

AGE/DATE OF BIRTH _____ SEX _____ ETHNICITY/NATIONALITY: _____

ID # (20/30 SPONSOR'S SS#) _____

CURRENT PAIN LEVEL (0 -10 SCALE): _____ Location of pain: _____

BARIATRIC PROCEDURE: (please circle): gastric bypass lap band sleeve I haven't decided

How long has weight been a problem? _____

Height = _____; greatest weight = _____; least weight as adult = _____; current weight = _____

My post surgery weight goal = _____ Have you been to the nutrition screening appt? _____

Why I want to have bariatric surgery: _____

Diets tried: _____

Current exercise: _____ Past exercise: _____

Exercise plans after surgery: _____

Have you attended the NMCP Bariatric Surgery Support Group? _____ Do you plan to attend? _____

Please list current medical problems: _____

List current medications and dosage: _____

What impact has weight had on your life? _____

Describe your sleep: _____

Describe your appetite (hungry all the time, not hungry, skips meals): _____

How would you describe your mood? _____

MENTAL HEALTH HISTORY

Have you ever felt depressed? If yes, when: _____

Have you ever thought of ending your life? If yes, when: _____

Have you ever thought of hurting or killing another person? If yes, when: _____

Have you ever participated in counseling or psychotherapy? If yes, please describe: _____

Have you ever taken medication for mental health symptoms? If yes, please describe: _____

PERSONAL AND FAMILY HISTORY

Place of birth: _____ Where did you grow up? _____

Father's age: _____ Health? _____ (If deceased, cause and age at that time): _____

Mother's age: _____ Health? _____ (If deceased, cause and age at that time): _____

Were your parents separated or divorced? _____ If yes, how old were you when that happened? _____

I have _____ brothers and _____ sisters. I was born 1st, 2nd, 3rd, etc _____

How would you describe your childhood? _____

Were you ever physically, sexually, or emotionally abused? _____ If yes, how old were you? _____

Highest grade/degree completed: _____

Employment status (full time, part time, unemployed): _____ Current job: _____

Has religion, faith, or spiritual beliefs been an important part of your life? YES/NO Currently? YES/NO

Are you married? _____ For how long? _____ Widowed / Separated / Divorced? _____

Describe relationship with spouse: _____

Ages of children: _____

Where do they reside? _____

Past or current legal problems: _____

SUBSTANCE USE HISTORY

Describe current alcohol use (none, rare, occasional, moderate, heavy): _____

Alcohol consumption (per week, month, or year): _____

Have you ever felt that you should cut down on your drinking? _____

Have people ever annoyed you by criticizing your drinking? _____

Have you ever felt guilty about your drinking? _____

Have you ever had a drink first thing in the morning (an eye opener or early morning drink) to steady your nerves or get rid of a hangover or residual drug effect? _____

Nicotine use (i.e., packs/day): _____ If you used nicotine, when did you stop? _____

Caffeine consumption per day: _____ Carbonated beverage consumption per day: _____

Please describe any significant changes or events in your life in the past 2 years. Were these positive or negative?
