LEIGH SCOTT ROSENBERG, PSY.D.
Licensed Psychologist (PY3608)
Diplomate, American Academy of Pain Management

Bariatric Presurgery Weight Loss Questionnaire ©

Your Name: _____ Age: _____ Sex: _____

Your Medical Providers:

Bariatric Surgeon: Dr. _____ Primary Care Physician: Dr. _____

What is your current weight ? _____ pounds

How much weight have you gained in the last year ? _____ pounds or ❑ Does not apply

How much weight have you lost in the last year ? _____ pounds or ❑ Does not apply

Proposed Bariatric Weight Loss Surgery:

- ❑ Gastric Banding
- ❑ Sleeve Gastrectomy ("Gastric Sleeve")
- ❑ Gastric Bypass ("Roux-en-Y Gastric Bypass")
- ❑ Biliopancreatic Diversion ❑ Biliopancreatic Diversion with Duodenal Switch

How soon would you like to have your bariatric weight loss surgery ?

❑ 1 month ❑ 3 months ❑ 6 months ❑ 9 months ❑ 1 year

❑ Whenever insurance authorization is okayed ❑ Other _____

Do you know others who have undergone bariatric weight loss surgery(ies) ? ❑ Yes ❑ No

If Yes, do you think their outcomes were: ❑ Positive ❑ Negative ❑ Mixed

Do you feel you have support from significant others for this weight loss surgery? ❑ Yes ❑ No

Have you already completed a consultation with a Nutritionist ? ❑ Yes ❑ No

Are you currently prescribed a specific weight loss / dietary program ? ❑ Yes ❑ No

If Yes, are you following it ? ❑ Yes ❑ No ❑ Not completely

If No, are you following any weight loss program ? ❑ Yes ❑ No ❑ Not completely

Are you taking prescribed weight loss or appetite suppressant medications ? ❑ Yes ❑ No

Are you currently exercising regularly for more than 15 minutes ?

❑ No If Yes, ❑ 1-2 times weekly ❑ 3-5 times weekly ❑ _____

What is the ideal weight range you want to reach after weight loss surgery ? _____ to ____ pounds

How long after weight loss surgery do you think it will take to reach your ideal weight range ?

❑ 6 months ❑ 1 year ❑ 18 months ❑ 2 years ❑ 30 months ❑ 3 years

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Reasons you want to have this bariatric weight loss surgery ?
(check off all that apply)

- ❑ Be able to shop in any clothing store
- ❑ Better quality of life
- ❑ Better sex life
- ❑ Buy a new wardrobe
- ❑ Decrease pain (back, legs, feet, etc.)
- ❑ Do my preferred hobbies
- ❑ Enjoy family activities again
- ❑ Exercise easier / more often
- ❑ Fit into airplane / theatre / ride seats
- ❑ For career advancement
- ❑ Have more friends, be more social
- ❑ Have others notice my good looks
- ❑ Improve self-esteem
- ❑ Improve my fertility
- ❑ Reduce or eliminate sleep apnea
- ❑ Reduce or eliminate acid reflux (GERD)
- ❑ Reduce diabetes medications
- ❑ Reduce blood pressure medications
- ❑ Reduce pain medications
- ❑ More freedom / mobility
- ❑ More energy-stamina daily
- ❑ To do more physically demanding things
- ❑ To live longer
- ❑ _____

Your Weight History

Do you have a family history of obesity ? ❑No ❑Yes (Who? _____)

How long have you had a weight problem? ❑Since childhood ❑Since teens ❑Since an adult
❑After each pregnancy ❑ After last pregnancy ❑Since start of chronic medical problems

To limit weight gain, have you ever tried anorexic (starving) behaviors ? ❑ No ❑ Yes

To limit weight gain, have you ever tried bulimic (vomiting) behaviors ? ❑ No ❑ Yes

Which of the following have been problem eating behavior patterns for you?

Large portions……..	❑No	❑ Yes	❑Current
Bad food choices……..	❑No	❑ Yes	❑Current
Emotional / Stress eating……..	❑No	❑ Yes	❑Current
Snacking……..	❑No	❑ Yes	❑Current
Sweets……..	❑No	❑ Yes	❑Current
Skipping meals……	❑No	❑ Yes	❑Current

What types of weight loss / diet programs have you tried ? (check all that apply)

- ❑ Atkins
- ❑ Acupuncture
- ❑ Best Life
- ❑ Cabbage Soup
- ❑ Deal-A-Meal
- ❑ Diet Pills
- ❑ Eat for Your Type
- ❑ Fat Flush
- ❑ Glycemic Index
- ❑ Grapefruit Diet
- ❑ Hormone
- ❑ Hypnosis
- ❑ Jenny Craig
- ❑ Liquid Diet
- ❑ Low Calorie
- ❑ Low Carbohydrate
- ❑ Macrobiotic
- ❑ Master Cleanse
- ❑ Medifast
- ❑ Mediterranean
- ❑ Metabolife
- ❑ Nutri-System
- ❑ Nutritionist
- ❑ Oprah Winfrey Diet
- ❑ Optifast 2
- ❑ Overeaters Anyms
- ❑ Fen-Phen
- ❑ Physician Wt. Loss
- ❑ Protein
- ❑ Richard Simmons
- ❑ Shangri-La
- ❑ Slimfast
- ❑ South Beach Diet
- ❑ Susanne Summers
- ❑ Transformations
- ❑ Volumetrics
- ❑ Weight Watchers
- ❑ Zone Diet
- ❑ Other: _____

What is the longest time you have consistently stayed on a weight loss program?
❑1 month ❑3 months ❑6 months ❑9 months ❑1 year ❑Longer _____
What is the most weight you have lost using any weight loss program ?
❑10-20 pounds ❑21-40 pounds ❑41-60 pounds ❑61-100 pounds ❑More _____

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Was regular exercise a component of any of your weight loss programs ? ❑Yes ❑No

What is the longest you have consistently stayed on an exercise program (even if not for weight loss) ?

❑Never ❑1 month ❑3 months ❑6 months ❑9 months ❑1 year or longer

Is your current weight your highest/maximum weight ? ❑Yes ❑No

If No, what was your highest/maximum weight in the past ? _____ pounds.

Have you experienced emotional distress due to your weight issues ? (check all that apply)

❑ No If Yes, ❑ low esteem ❑ dislike my body ❑ depression ❑ anxiety ❑ social withdrawal

❑ Other: _____

Your Personal / Family / Medical Background History

How many grades (1-12) did you complete: _____ History of Special Education: ❑Yes ❑ No

Graduation year: _____ GED year: _____ Dropout Reason: _____

Have you attended 2 or 4 year college: ❑Yes ❑ No Attended vocational / trade school: ❑Yes ❑No

Degrees, licenses, certifications earned: _____

Military Experience (Branch / Years): _____ Combat: ❑Yes ❑ No

What type(s) of work have you done as an adult: _____

Are you employed: ❑Yes ❑ No Currently on Medical Leave or Worker's Compensation: ❑Yes ❑No

If Yes, Employer / Job Title : _____ or ❑ Self-Employed

Medical History - Problems / Diagnoses:

❑ No	❑ Yes	Arthritis (_____)	❑ No	❑ Yes	High BP / Hypertension
❑ No	❑ Yes	Cancer (_____)	❑ No	❑ Yes	Hepatitis / HIV+ (AIDS)
❑ No	❑ Yes	Chronic Pain: (_____)	❑ No	❑ Yes	Migraine Headaches
❑ No	❑ Yes	Chronic Fatigue Syndrome	❑ No	❑ Yes	Muscle Tension Headaches
❑ No	❑ Yes	Diabetes	❑ No	❑ Yes	Seizure (s) – Epilepsy
❑ No	❑ Yes	Fibromyalgia Syndrome	❑ No	❑ Yes	Stroke(s) or TIA's
❑ No	❑ Yes	GERD (Acid Reflux)	❑ No	❑ Yes	Traumatic Brain Injury
❑ No	❑ Yes	Heart Attack (_____)			

Other Medical Conditions: _____

All Previous Surgeries: _____

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Mental Health History

Regardless of cause, whether related or not related to your weight issues .....

Do you often feel depressed ?..... ❑ No ❑ Yes
Do you often feel anxious or nervous ?..... ❑ No ❑ Yes
Do you often have trouble controlling your impulses ? ..... ❑ No ❑ Yes
Do you often have difficulty with irritability ? ..... ❑ No ❑ Yes
Do you ever wish you were dead and away from it all?..... ❑ No ❑ Yes
Are you satisfied with your social life?..... ❑ No ❑ Yes
How would you rate your current energy level?..... ❑ High ❑ Moderate ❑ Low
How would you rate your current self esteem level?..... ❑ High ❑ Moderate ❑ Low

Were you ever emotionally, physically and/or sexually abused? ..... ❑ No ❑ Yes
Do you have any history of alcohol abuse ? ..... ❑ No ❑ Yes
Do you have any history of street drug abuse ? ..... ❑ No ❑ Yes
Do you have any history of prescribed drug abuse ? ..... ❑ No ❑ Yes

Have you ever been treated by a Psychiatrist with prescribed medications ? ..... ❑ No ❑ Yes
Have you ever been prescribed psychiatric medications by any physician ? ..... ❑ No ❑ Yes
Have you ever been hospitalized for psychiatric reasons?..... ❑ No ❑ Yes
Have you ever been treated by a Psychologist or Mental Health Counselor ? ..... ❑ No ❑ Yes

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