

**Johns Hopkins Weight Management Center
Bariatric Surgery Assessment and Presurgical Education
Questionnaire**

Full Name _____

Address _____

City _____ State _____ Zip _____

Phone (Home) _____ (Work) _____

Date of Birth _____ Age _____ Sex ____ Race _____

Type of Surgery Desired Gastric Bypass Lap Band Biliopancreatic Diversion with Duodenal Switch

Surgical date _____ Physician _____

Prior research on procedure _____

Medications _____

Food allergies or intolerances _____

MEDICAL HISTORY: check if you (or any family member) have or have had any of the following. Please explain any "yes" answers on the back of this sheet.

Condition	You	Relative (List Who)	Condition	You	Relative (List Who)
High Blood Pressure			Gallbladder disease		
Heart Disease			Liver disease		
Yellowing			Chest pain		
Thyroid Disease			Irregular heartbeat		
Kidney Disease			Alcoholism or drug abuse		
Shortness of Breath			Arthritis		
Stroke			Cancer		
Swelling of feet			Anemia		
Frequent headaches			Low back pain		
Seizures or epilepsy			Gout		
Psychological difficulties			Ulcers		
Psychiatric conditions			Constipation		
Depression			Chronic diarrhea		
Anxiety or panic attacks			Heartburn		
Hemorrhoids			Gas/ bloating		
Asthma			Chronic cough		
Phlebitis			Allergies		
Fainting/ lightheaded			Dizziness		
Diabetes			Frequent nausea		
Loss of muscle strength			Numbness in hands/ feet		
High cholesterol			Sleep difficulties		
Other					

Past Hospitalizations (include psychiatric as well as operations):

Year	Reason

Height _____ Wt _____ Highest adult wt _____ Lowest adult wt _____ Age at that wt _____

Please record your major diets which resulted in a weight loss of 10 lbs. or more.

DIET	AGE	WEIGHT AT START OF DIET	POUNDS LOST	COMMENTS
1				
2				
3				
4				
5				
6				

For each time period, please record your maximum weight. If you cannot remember, make your best guess and mark "G." **Please note any events related to your weight during this period (i.e., in college, pregnant, end of relationship).**

Age	Maximum Weight	Events Related to Weight Gain
5-10		
11-15		
16-20		
21-25		
26-30		
31-35		
36-40		
41-50		
51-60		
60+		

How many times have you intentionally lost 20 lbs. or more and then gained it back?

Never _____ Once or twice _____ 3-4 times _____ 5 times or more _____

Family History of Overweight (use back of page if needed):

Relative	Age (or age at death)	Living (Y/N)	Degree of Overweight			
			None	Slight (5-15 lbs)	Moderate (16-49 lbs)	Very (50+ lbs)
Father						
Mother						
Brother – oldest						
2 nd oldest						
3 rd oldest						
Sister – oldest						
2 nd oldest						
3 rd oldest						
Father's mother						
Father's father						
Mother's mother						
Mother's father						
Spouse/ partner						

How often do you eat at:	2-3 times/d	1 time/d	2-3 times/wk	1 time/wk	2-3 times/ mo
Fast food restaurants					
Vending machines					
Cafeterias					
Hot dog/ food stands					
Full service restaurants					
Other _____					

1) During the past 6 months, did you often eat within any 2 hour period what most people would regard as an unusually large amount of food? Yes _____ No _____

If you answered yes, please continue with the following questions. If you answered no, proceed to question 2.

- a. During the times when you ate this way, did you often feel you couldn't stop eating or control what or how much you were eating? Yes _____ No _____
- b. During the past 6 months, how often have you eaten this way (large amounts of food along with the feeling that your eating was out of control)?
Less than 1 day/wk ___ 1 day/wk ___ 2-3 days/wk ___ 4-5 days/wk ___ 6-7 days/wk _____
- c. Did you experience any of the following during these occasions?

	Y	N		Y	N
Eating more rapidly than usual			Eating alone because of embarrassment about amount of food eaten		
Eating until uncomfortably full			Feeling disgusted, depressed or guilty after overeating		
Eating when not physically hungry					

d. What time of day did this type of eating occur?

Morning (8 am to noon) _____ Early afternoon (noon to 4 pm) _____
 Late afternoon (4-7 pm) _____ Evening (7-10 pm) _____ Night (after 10 pm) _____

e. Approximately how long did the episode last (from the time you started eating to when you stopped and didn't eat again for at least 2 hours)? _____ hours _____ minutes

f. At the time the episode started, how long had it been since you had previously finished eating a meal or a snack? _____ hours _____ minutes

g. As best you can remember, please list everything you might have eaten or drank during the episode. Be specific. Include brand names where possible, and your best estimate of amounts. Example: 7 ounces of Lays cheddar cheese potato chips; 2 cups of Lucerne chocolate ice cream with 3 tablespoons of hot fudge; 1 16-ounce bottle of Coca-cola; 1 ½ sandwich with ham, cheese, lettuce and tomato, mayonnaise and mustard.

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h. How old were you when you first had times when you ate large amounts of food and felt that your eating was out of control? (If not sure, give best guess) _____ years

2) In general, during the past 6 months, how important has your weight or shape been in how you feel about yourself as a person (as compared to other aspects of your life, such as how you do at work, as a parent, or how you get along with other people)?

	Y	N
Weight and shape were not very important		
Weight and shape played a part in how I felt about myself		
Weight and shape were among the main things that affected how I felt about myself		
Weight and shape were the most important factors in how I felt about myself		

3) During the past 6 months, how upset were you by overeating (eating more than you think is best for you)?

Not at all _____ Slightly _____ Moderately _____ Greatly _____ Extremely _____

4) Have you attempted any of the following behaviors in order to prevent gaining weight?

	Number of times/wk						
	Y	N	<1	1	2-3	4-5	6-7
Taking more than twice the recommended dose of diet pills							
Taking more than twice the recommended dose of laxatives							
Taking more than twice the recommended dose of diuretics							
Vomiting after eating							
Abstaining from food for more than 24 hours							
Exercising more than an hour							

Please indicate if you are currently experiencing stress in your life related to the following events:

	Y	N		Y	N
Work or possible job change			Children (birth, parenting issues, etc)		
Relationships (marriage, divorce, end of relationship)			Financial difficulties		
Beginning/ending college			Death of friend or relative		
Moving			Other _____ _____		

Do you smoke cigarettes? Yes _____ No _____ If yes, # per day _____ # of years _____

Do you drink alcohol? Yes _____ No _____

If yes, type and amount of alcohol per week _____

Do you gamble? Yes ___ No ___ If so, how often? _____

Does the amount of shopping you do create a problem for you (financial, personal, etc.)? _____

Do you have any compulsive behaviors? _____

Have you every participated in counseling or psychotherapy? Yes _____ No _____

If yes, type: Individual _____ Family _____ Couples _____ Substance abuse _____

Please describe when, with whom, and for what reason: _____

Have you ever been the victim of abuse (physical, emotional, or sexual)? Yes _____ No _____

Are you planning any major life changes in the next year? Yes _____ No _____

If yes, what? _____

What is the most significant source of stress at this time? _____

What are you doing about it? _____

What is one thing in your life you would like to accomplish/complete and why? (other than to lose weight)?

Think back on other weight loss attempts. How are you most likely to sabotage your efforts, both short-term and long-term?

Current physical activity/limitations _____