Delta Family Clinic South P.C.

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Bariatric Treatment Questionaire

PATIENT NAME:_____ AGE_____ SEX: M F

ADDRESS:_____ CITY_____STATE_____ ZIP_____

HOME PHONE:_____ DATE OF BIRTH_____/_____/_____

1. Patient Occupation:_____
2. Referred by Dr. _____ at the _____ Weight loss surgery center.
3. How long would you consider yourself as being overweight? _____

   _____
4. How long would you consider yourself as being *seriously* overweight? _____

   _____
5. What efforts have you taken to lose weight?_____

   _____
6. What is your motivation for seeking this weight loss surgery? _____

   _____
7. Have you ever seen a mental health therapist or counselor before? Yes No

   When?_____ For?_____
8. Have you ever taken an anti-depressant medication? Yes No
   What medication(s) _____ For how long? _____
9. Have you ever experienced bulimia or anorexia? Yes No When? _____
10. Have you ever attempted suicide? Yes No When? _____
11. Have you ever been diagnosed with a substance abuse disorder? Yes No
12. My current intake of alcohol over the past year is _____ alcoholic beverages per _____ (week/month/year).

13. Over the past year I have used the following recreational drugs: _____

    _____ every _____ (week/month/year).

14. I have participated in _____ prior psychological testings or evaluations for:

    _____ on the following dates _____.

15. Have you ever been diagnosed with the following:

Severe Depression	Y	N
Bipolar or Manic-Depressive Disorder	Y	N
Impulse Control or Obsessive Compulsive Disorders	Y	N
Addictive Behaviors	Y	N
Schizophrenia	Y	N

16. Have there been any of the following kinds of problems with any of your blood Relatives?

Sever temper tantrums or mood problems?	Y	N
Mental illness?	Y	N
Problems with alcohol or drug use?	Y	N
Physical or sexual abuse?	Y	N
Criminal behavior?	Y	N
Homicidal or suicidal behavior?	Y	N

    Briefly explain any answers to the above: _____

    _____

    _____

_____ _____
Patient Signature Date

_____ _____
Reviewing Clinician Signature Date