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Bariatric Evaluation Information Sheet

Name: _____ Age: _____ Marital Status: _____

Who will be performing your weight loss procedure?

Name:_____

Address: _____ City: _____ Zip: _____

Phone: _____ Fax: _____

Previous Marriages: # _____ Height: _____ Present weight: _____

Goal Weight: _____ Weight: Lowest: _____ Highest: _____

Household (list names / relationship, and ages of people in your household) :

_____

_____

Are they supportive of your surgery:_____

Briefly, what is your history of attempting to loose weight in the past and when?

_____

_____

_____

_____

Have you been hospitalized for psychological treatment: _____

Are you currently receiving mental health services of any kind? _____ Describe:

_____

Psychotropic Medications: _____

Why are you pursuing weight loss surgery: _____

_____

_____

Check List: indicate yes or no and amount….
___ Alcohol _____
___ Smoking _____
___ Exercise _____ none ____ times per week : Amount:_____
___ Drug Use / describe: _____
___ Previous sexual Abuse: If any, Describe:
_____

Have you consulted with a dietician and have an eating plan: _____

Support Group: Describe any educational / support group meetings you have or will attend to prepare for this surgery. When?
_____
_____

Describe any significant difficulties or traumas in your lifetime:
_____
_____
_____

Do you have any concerns regarding your up coming surgery:

_____

(Write below any additional information that might be helpful for this evaluation.)
Thank you!