**Bariatric Procedure Psych Evaluation Questionnaire**

Please complete ONLY IF you are being seen for a one time psychiatric evaluation for spinal cord stimulator.

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date Of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Height**: \_\_\_\_\_\_\_ Feet \_\_\_\_\_\_\_\_\_ Inches

**Weight**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ lbs

**Please list any diets or medications that you have tried in the past for weight loss:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| **1. Would you say that food dominates your life?** |  |  |
| **2. Have you made yourself vomit to counteract the effects of eating, or made yourself vomit because you feel uncomfortably full?** |  |  |
| **3. Have you used laxatives or diuretics to prevent weight gain, or counteract the effects of eating?** |  |  |
| **4. Have you engaged in excessive exercise specifically to counteract the effects of eating?** |  |  |

**Which procedure are you being evaluated for?**

\_\_ Gastric Bypass

\_\_ Gastric Sleeve

\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_