Northwestern Medicine®

Bariatric Surgery and Metabolic Health Program at Delnor Hospital and Central DuPage Hospital

Initial Assessment

Name: ______________________ Date: ______________

BACKGROUND QUESTIONS

Preferred phone: ______________________ Email: ______________________

Occupation: ______________________ Best time to reach you: ______________________

Marital status (please check): Single Married Divorced Widowed Partnered

Please list the names of the people in your household and how they are related to you:

______________________ ______________________

______________________ ______________________

What is the highest level of education you completed? ______________________

Why are you seeking services? ______________________

What personal goals can we help you achieve? ______________________

What services are you most interested in?

BARIATRIC SURGERY

- Gastric bypass
- Gastric sleeve
- Laparoscopic gastric band (LAP BAND®)

MEDICAL WEIGHT MANAGEMENT

- Lifestyle changes
- Weight loss medications (if appropriate)
- New Direction®

Continued >

Initial Assessment (continued)

GENERAL HEALTH QUESTIONS

Primary care provider: ______________________________ Phone: ______________

Address: ____

When was your last physical exam? ______________ When were your last blood tests? ___________

How would you rate your health? (please check): Excellent Good Fair Poor

Height: __________ Current weight: ______

MEDICAL HISTORY Mark (x) all that apply:

- Acid reflux (GERD)
- Anemia
- Anorexia
- Anxiety
- Arthritis
- Asthma/lung problem
- Attention deficit disorder (ADD/ADHD)
- Bipolar disorder
- Bleeding disorders
- Blood clot/DVT
- Bulimia
- Cancer
- Celiac disease
- Congestive heart failure
- Drug/alcohol dependency
- Depression
- Diabetes (type 1)
- Diabetes (type 2)
- Emphysema/chronic bronchitis
- Epilepsy/seizure disorder
- Fatty liver disease
- Gallbladder disease/stones
- Glaucoma
- Gout
- Heart disease/heart attack
- Heart murmur
- Hepatitis
- High blood pressure/ hypertension
- High cholesterol
- HIV disease
- Irregular menstrual periods
- Impaired fasting glucose/ pre-diabetes
- Kidney disease/stones
- Liver disease
- Migraines
- Multiple sclerosis (MS)
- Obsessive compulsive disorder (OCD)
- Osteoporosis/penia
- Polycystic ovarian syndrome (PCOS)
- Pacemaker
- Prostate problem
- Sickle cell disease
- Sleep apnea
- Stroke
- Thyroid disease
- Tuberculosis
- Ulcer disease
- Other

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____

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Continued >

Initial Assessment (continued)

Average hours of sleep each night: ______________________ Do you feel refreshed after you sleep? Yes No

How would you rate your stress level? **Low** 1 2 3 4 5 **High**

How do you deal with the stress of daily life? ____

Are you currently seeing a mental health professional? Yes No

If yes, please add name and contact information: ____

List all previous surgeries with date: ____

____

List your current medications and dosages. (Include any vitamins and supplements.)

1. ______________________ 5. ______________________

2. ______________________ 6. ______________________

3. ______________________ 7. ______________________

4. ______________________ 8. ______________________

Are you allergic to any medications? ____

Tobacco history (please check): Never smoked Used to smoke Currently smoke _______ (packs per day)

Alcohol history (please check): Do not drink Currently drink _______ drinks per week

Recreational drug use (please check): Never Used to use Currently use

Type ______________________

How often ______________________

FAMILY HEALTH HISTORY

RELATION	AGE	MEDICAL CONDITIONS	OVERWEIGHT OR OBESE?	AGE AT DEATH
Father				
Mother				
Siblings				

Continued >

Initial Assessment (continued)

RELATION	AGE	MEDICAL CONDITIONS	OVERWEIGHT OR OBESE?	AGE AT DEATH
Partner				
Children				

NUTRITION QUESTIONNAIRE

What would you like to change about your diet? ______________________________

Do you read food labels? If yes, what do you look for? ______________________________

How confident are you about the *amount* of current nutrition knowledge you have? **Low** 1 2 3 4 5 **High**

How confident are you about your ability to *apply* the nutrition knowledge you have? **Low** 1 2 3 4 5 **High**

Do you have any food allergies? If yes, please list: ______________________________

Do you follow any special diet or dietary restrictions? If yes, please explain:

____

When and what do you usually eat in a typical day? Please list what you eat and drink in a **normal** day in the table below:

BREAKFAST	SNACK	LUNCH	SNACK	DINNER	SNACK	FLUIDS

Continued >

Initial Assessment (continued)

What do you usually drink throughout the day? ______________________________

How many meals per week do you eat in restaurants/order takeout? ______________________

The following questions ask about your eating patterns and behaviors within the last 3 months. For each question, choose the answer that best applies to you.

During the last 3 months, did you have any episodes of excessive overeating (i.e., eating significantly more than what most people would eat in a similar period)?

Yes No

NOTE: IF YOU ANSWERED "NO" TO QUESTION 1, YOU MAY STOP. THE REMAINING QUESTIONS DO NOT APPLY TO YOU.

Do you feel distressed about your episodes of excessive overeating?

Yes No

During your episodes of excessive overeating, how often did you feel like you had no control over your eating (e.g., not being able to stop eating, feel compelled to eat, or going back and forth for more food)?

Never or Rarely Sometimes Often Always

During your episodes of excessive overeating, how often did you continue eating even though you were not hungry?

Never or Rarely Sometimes Often Always

During your episodes of excessive overeating, how often were you embarrassed by how much you ate?

Never or Rarely Sometimes Often Always

During your episodes of excessive overeating, how often did you feel disgusted with yourself or guilty afterward?

Never or Rarely Sometimes Often Always

During the last 3 months, how often did you make yourself vomit as a means to control your weight or shape?

Never or Rarely Sometimes Often Always

Do you have a history of an eating disorder? If yes, please check:

Compulsive overeating Binge eating disorder Anorexia Bulimia

Do you feel that you have a food addiction (loss of control over how much food you eat)? Yes No

Continued >

Initial Assessment (continued)

PHYSICAL ACTIVITY QUESTIONNAIRE

What is the most active thing you do in an average day? ____________________

What, if any, regular exercise do you do and how often? ____________________

In general, how much do you enjoy doing physicial activity? Please rate below:

Low enjoyment 1 2 3 4 5 **High enjoyment**

What makes it hard for you to exercise? ____________________

Is there any other reason why you do not do physical activity? Yes No

When you exercise or exert yourself, do you have any of the following? Please check any that apply:

Shortness of breath Chest pain or pressure Pain in your calves

WEIGHT HISTORY

What has been your lowest body weight as an adult? __________ lbs. At what age? __________

What was your highest body weight as an adult? __________ lbs. At what age? __________

Have you participated in a commercial or professional weight loss program before? Yes No

If yes, please check which ones:

Weight Watchers Jenny Craig NutriSystem Weight Loss Medication __________
(name of medication)

Other ____________________

Have you seen a registered dietitian (RD) before? Yes No

Have you ever had weight loss surgery? If so, which one and when? ____________________

What is the most amount of weight you've lost in the past? __________ lbs.

What are the biggest challenges you have in losing weight/maintaining weight loss? ____________________

____

How important is it for you to make lifestyle changes?

Very important 1 2 3 4 5 **Not important**

How confident are you in your ability to make lifestyle changes?

Very confident 1 2 3 4 5 **Not confident**

Continued >

Initial Assessment (continued)

SIX-FACTOR TRAIT QUESTIONNAIRE (6-FTQ) Please check your level of agreement to all statements:

	Disagree	Agree a little	Agree	Strongly agree
CONVENIENT DINER				
1. I rarely take the time to plan my meals.	0	1	2	3
2. A lot of my meals are eaten in restaurants or taken out.	0	1	2	3
3. Most foods I eat are convenient, ready-made, packaged, frozen or microwavable.	0	1	2	3
4. I eat a fast-food meal on most days of the week.	0	1	2	3
5. I do not have consistent meal patterns from one day to the next.	0	1	2	3
Add up your total for this section:				
FAST PACER				
6. My fast-paced life leaves me feeling drained and scattered.	0	1	2	3
7. I feel like I'm juggling too many things at once.	0	1	2	3
8. I usually take care of everyone else and put myself at the bottom of my to do list..	0	1	2	3
9. My hectic schedule makes it hard for me to focus on my health.	0	1	2	3
Add up your total for this section:				
EASILY ENTICED EATER				
10. I have difficulty controlling my portion sizes.	0	1	2	3
11. I often eat out of habit, not because I am hungry.	0	1	2	3
12. When I'm stressed, lonely, anxious or depressed, I turn to food for comfort.	0	1	2	3
13. If there is food around me, I'll probably eat it.	0	1	2	3
14. I snack throughout the day, hungry or not.	0	1	2	3
15. I will eat until I'm too full and may even eat more.	0	1	2	3
Add up your total for this section:				

Continued >

Initial Assessment (continued)

SIX-FACTOR TRAIT QUESTIONNAIRE (6-FTQ) Please check your level of agreement to all statements:

	Disagree	Agree a little	Agree	Strongly agree
EXERCISE STRUGGLER				
16. Being physically active has never been a priority.	0	1	2	3
17. I don't enjoy exercise because I don't like it.	0	1	2	3
18. I never got "into" exercising because I am not sure where to start.	0	1	2	3
19. I have difficulty exercising.	0	1	2	3
Add up your total for this section:				
SELF-CRITIC				
20. I measure my self-worth by the numbers on the bathroom scale.	0	1	2	3
21. I focus on the things I don't like about my body.	0	1	2	3
22. I make a habit of saying bad things about myself.	0	1	2	3
23. I avoid social situations because of my weight.	0	1	2	3
Add up your total for this section:				
ALL-OR-NOTHING DOER				
24. I approach my weight loss like it's just another project with a clear beginning and end.	0	1	2	3
25. I'm either on or off my diet. There's no middle ground with me.	0	1	2	3
26. When I'm trying to lose weight, I give 100% of my effort, but this is hard to sustain.	0	1	2	3
27. I am all or nothing when it comes to dieting or exercising to lose weight.	0	1	2	3
Add up your total for this section:				

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