BEHAVIORAL
HEALTH

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POST-BARIATRIC SURGERY UPDATE QUESTIONNAIRE

INSTRUCTIONS

1. Your physician or health insurance company has requested a mental health follow-up 3 months after weight-loss surgery. This questionnaire is designed to assess how you are doing emotionally and whether you have been experiencing any mood, mental, or adjustment problems since your operation.

2. You can return this paperwork by fax or in-person. You may also mail it to our hospital mailing address at Behavioral Health Dept, Family Health West, PO Box 130, Fruita, CO 81521. If you prefer, an electronic version on our website is also available.

3. Some of the questions are of a sensitive or personal nature. The provider and office staff will safeguard your privacy in compliance with current legal and ethical standards and will release information only to other professionals whom you have authorized and for whom you have signed consent. Please note that there are limitations to confidentiality when your safety or the safety of others may be compromised, and you can discuss any questions you might have about this with your provider.

4. Read each of the items carefully and answer honestly. If you are not certain of an answer, please give your best response. Be aware that your answers may be compared with information obtained from other medical records.

5. Some items may ask for information that you have already answered on this or on other medical forms or questionnaires. We apologize for the repetitiveness. Please answer these items anyway.

6. If an item seems unclear or if you have questions, you may make a notation on the questionnaire or ask the provider directly.

7. Thank you for your cooperation in filling out this form accurately and completely.

Post-Surgical Psychological Update Information

Name __________________________________ Date of Birth _____________ Age____ Today's Date______________
Residential Address____ City____________________ State_________

1. What date did you have surgery? _________________________ Who was the surgeon? ______________________

2. What type of surgery did you have (gastric bypass, sleeve, duodenal switch)?
____

3. Were there any complications during or after surgery? Yes No If "yes," please explain:
____
_______ ____

4. Since having weight loss surgery, which, if any, of the following complications have you experienced?

❒ Nausea	❒ Vomiting	❒Regurgitation	❒Difficulty swallowing
❒ Dumping syndrome	❒ Food getting "stuck"	❒ Acid reflux	❒ Throat pain
❒ Coughing/choking	❒ Stomach pain	❒ Constipation	❒ Distorted smell/taste
❒ Diarrhea	❒ Little or no weight loss	❒ Excessive weight loss	❒ Malnutrition

5. What is your current weight? _____________lbs. Height? ______ft. ______in.

6. What is your goal weight? _____________lbs.

7. Overall, since surgery, how have you been doing (mentally, physically, socially)?
❒ Poor ❒ Fair ❒ Average ❒ Good ❒ Excellent

8. How well have you been keeping up with a post-surgical nutritional plan?
❒ Poor ❒ Fair ❒ Average ❒ Good ❒ Excellent

9. How well are you following an activity or exercise plan?
❒ Poor ❒ Fair ❒ Average ❒ Good ❒ Excellent
What types of exercises do you do? ____
How frequently? ____

10. Are you seeing a counselor, psychiatrist, or other type of mental health professional? ❒ Yes ❒ No
If yes, who do see? ____________________________________ How often? ___________________________________

11. Do you take medication for depression, anxiety, or other mood symptoms? ❒ Yes ❒ No
If yes, what medications? ____

12. Since surgery, have you participated in any support groups? ❒ Yes ❒ No
If "yes," please specify which group(s): ____
On what dates did you attend? ____

13. Since you were last here, have you been under a doctor's care for any changes or problems (unrelated to weight loss surgery) in your medical health? ❒ Yes ❒ No
If "yes," please describe:

____

____

14. Since you were last here, have there been any changes in your medications? ❒ Yes ❒ No
If "yes," please describe: ____

____

15. Please check any of the symptoms listed below that you have experienced ***since surgery***:

❒ Depression	❒ Mood swings	❒ Obsessive thoughts
❒ Discouragement	❒ Racing thoughts	❒ Compulsive behaviors
❒ Frustration	❒ Excessive energy	❒ General anxiety
❒ Persistent unhappiness	❒ Insomnia	❒ Social anxiety
❒ Helplessness	❒ Impatience	❒ Nightmares
❒ Hopelessness	❒ Irritability	❒ Flashbacks
❒ Low self-worth	❒ Agitation/anger	❒ Exaggerated startle
❒ Crying spells	❒ Distractibility	❒ Feeling disconnected
❒ Loss of pleasure/interest	❒ Impulsivity	❒ Gambling problems
❒ Thoughts of death	❒ Risk taking	❒ Computer addiction
❒ Self-harmful behaviors	❒ Hyperactivity	❒ Problems with pornography
❒ Loneliness	❒ Confusion	❒ Eating problems
❒ Withdrawal/Isolation	❒ Memory problems	❒ Alcohol/drug use
❒ Grief	❒ Judgment problems	❒ Suspicion/paranoia
❒ Guilt/shame	❒ Excessive worry	❒ Hearing voices
❒ Lack of motivation	❒ Panic attacks	❒ Visual hallucinations
❒ Feeling overwhelmed	❒ Phobias	❒ Other disturbing thoughts

Have you had any self-harmful thoughts, feelings, or behaviors? ❒ Yes ❒ No
If "yes," please explain: ____

16. ***Over the last 6 weeks***, how often have you had any of the following symptoms?

Feeling nervous, anxious or on edge:
❒Not at all ❒ Several days ❒ More than half the days ❒ Nearly every day

Unable to stop or control worrying:
❒Not at all ❒ Several days ❒ More than half the days ❒ Nearly every day

Little interest or pleasure in doing things:
❒Not at all ❒ Several days ❒ More than half the days ❒ Nearly every day

Feeling down, depressed, or hopeless:
❒Not at all ❒ Several days ❒ More than half the days ❒ Nearly every day

Feeling cheerful and in good spirits:

❒Not at all ❒ Several days ❒ More than half the days ❒ Nearly every day

Feeling calm and relaxed:

❒Not at all ❒ Several days ❒ More than half the days ❒ Nearly every day

Awakened feeling fresh and rested:

❒Not at all ❒ Several days ❒ More than half the days ❒ Nearly every day

Feeling satisfied with my life and circumstances:

❒Not at all ❒ Several days ❒ More than half the days ❒ Nearly every day

17. Have there been any changes, that have concerned you, in your relationship with spouse, significant other, or family members? ❒ Yes ❒ No
If "yes," please describe:

____

____

18. Have there been any changes, that have concerned you, in your employment, social relationships, or interactions with others? ❒ Yes ❒ No
If "yes," please describe:

____

____

19. Since surgery, have you used alcohol? ❒ Yes ❒ No If "yes," what do you drink? ____________________
How much? _______________How often? ______________

Have you used tobacco or nicotine products? ❒ Yes ❒ No

Have you used marijuana or other recreational substances? ❒ Yes ❒ No

20. Have you had to rely on narcotic pain medication? ❒ Yes ❒ No

21. Do you feel that you should see a counselor, therapist, or other mental health professional for any reason?
❒ Yes ❒ No If "yes," please explain: ____

____

Thank you for your patience in filling out this questionnaire! If you have answered all the questions, this is now complete.

Is there anything else you want us to know? If so, write some notes below.