# Bariatric New Patient Assessment

## NUTRITION

Describe your personal goal for joining a weight loss management program: _____

_____

Desired Weight: _____ Would like to be at desired weight by: _____# of Years Overweight: _____

Maximum Lifetime Weight (non-pregnant) and when? Weight:_____ lbs. Date:_____

Have you ever tried dieting to lose weight? ___No ___Yes

Have you ever tried using medication to lose weight? ___No ___Yes

Have you ever had weightloss surgery? ___No ___Yes

## PSYCHO-SOCIAL

Please describe your relationship with each of the following:

| | Excellent | Satisfactory | Unsatisfactory | N/A |
|---|---|---|---|---|
| **Spouse/ Significant Other** | | | | |
| **Child(ren)** | | | | |
| **Other Family** | | | | |
| **Job** | | | | |
| **Finances** | | | | |
| **Other:** | | | | |

Describe your daily stress level: ___None ___Low ___Minimal ___Moderate ___ High ___Very High

What do you do to handle stress? _____

Do you have a history of physical, sexual, or emotional abuse? ___No ___Yes, describe:_____

_____

_____

Have you ever attempted suicide? ___No ___Yes, # of attempts:_____, date of last attempt:_____

Have you ever received treatment for psychiatric illness (ex. Depression)? ___No ___Yes

If yes, Type of illness:_____

## SLEEP HABITS

Do you have difficuly sleeping? ___No ___Yes, describe_____

_____

Do you snore? ___No ___Yes Has anyone ever told you that you snore? ___No ___Yes

Have you ever been told you have obstructive sleep apnea? ___No ___Yes

Have you ever had a sleep study done? ___No ___Yes, Year:_____ Doctor:_____

Do you have a CPAP/BIPAP (circle one) machine? ___No ___Yes, Setting:_____

Do you use your CPAP/BIPAP machine every night? ___No ___Yes

If no, reason:_____

History of apparent airway obstruction during sleep. Check the following that apply:

___Snoring (loud enough to be heard through a closed door) ___Frequent snoring

___Awakens from sleep with choking sensation ___Frequent arousals from sleep

___Observed pauses in breathing during sleep ___Talking in your sleep

History of somnolence. Check the following that apply:

___Somnolence or fatigue, despite adequate sleep

___Falls asleep easily in a nonstimulating envitoment despite adequate sleep

___Difficult to arouse at usual awakening time

## ANESTHESIA HISTORY

Has any family member had a problem with anesthesia? ___No ___Yes, describe_____

_____

Have you had a problem with anesthesia? ___No ___Yes, describe_____

_____

Do you have difficulty moving your head side-to-side? ___No ___Yes

Do you have difficulty opening or closing your jaw? ___No ___Yes