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# BARIATRIC UPDATE FORM

*For patients who previously have seen Dr. Sethre for a pre-surgery psychological assessment, and need an update report from him.*

(you may write in the notes section on each page, or attach additional sheets if more space is needed)

Name: _____ Date of Birth: _____

Name of Bariatric Program: _____
Name of surgeon: _____
Date of last appointment with Dr. Sethre (estimate, if needed)_____
Are you currently working with a bariatric program dietician? ___ no ___ yes
If yes, what changes does the dietician have you working on?
_____

Height: _____ Current weight: _____
Highest weight since last seeing Dr. Sethre _____
Post-surgery weight loss goal: _____

Please list any new medical problems that you have developed since seeing Dr. Sethre
_____
_____

Please list all your current mediations (or attach a list):
_____
_____
_____
Is your primary medical provider currently supportive of you having bariatric surgery?
___ yes
___no. If no, what is your understanding of why the medical provider is concerned about you having bariatric surgery? _____

(notes)

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How often do you currently drink carbonated and caffeinated beverages:
_____
Do you currently smoke or otherwise use nicotine products? ___no ____ yes

Do you currently have problems with eating too much high calorie foods? __ no __ yes
Do you currently have a problem with excessive portions? ___ no ___ yes
If yes to the last two questions, please provide more specific info: _____
_____
Are you *currently* doing any of the following to try to lose weight?
_____ made yourself vomit
_____used laxatives or diuretics
____ starved yourself
Do you currently have any of the following patterns?
____ grazing (eating small amounts of food throughout the day)
____ lack of satiation (not feeling satisfied after eating a nutritious meal)
____ snacking after your evening meal
____ night eating (getting up during the night to eat)

Please briefly list all of weight loss programs that you have tried since last seeing Dr. Sethre, and results:
_____
_____
_____
_____

How often do you currently exercise, what do you do, and for how long do you do the activity?
_____
_____

Are you currently seeing a psychiatrist, psychologist, counselor or other mental health professional, or in a mental health program? ___ no ___ yes
If yes, please provide the name(s): _____
If so, please provide current psychiatric (including for anxiety, depression and ADHD) medications:_____
_____

(notes)

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Since last seeing Dr. Sethre, have you experience suicidal thinking, or attempted suicide? ___ no ___ yes If yes, Dr. Sethre will option more info from you.

Do you have any current concerns about:

- Memory and concentration: ___no ___ yes
- Depression: ___ no ___ yes
- Anxiety: ___ no ___ yes

If yes to any of the last 3 questions, please provide some info about what concerns you:
_____
_____
Please list any other current mental health problems or concerns that you have:
_____

Do you currently use alcohol? ___no ___ yes
If yes, please list your average number of drinks:
____ per day ____ per week ____ per month ____ per year
Do you currently use marijuana: ___ yes ___ no If yes, how often:
_____
Are you currently prescribed pain medication? ___ no ___ yes

Since last seeing Dr. Sethre, have you had chemical dependency treatment? __ No
__ Yes If yes, Dr. Sethre will obtain more info from you.

Do you have any concerns about whether mental health problems or use of alcohol or drugs will interfere with your ability to follow the aftercare program for bariatric surgery?
___no ___ yes
If yes, please briefly describe your concerns:
_____
_____

How many hours of TV do you watch (sitting and watching, not just TV in the background) in the average day? ___ less than two hours ___ 2 to 4 hours ____ more than 4 hours

(notes)

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How would you currently describe your sleep?
____ I feel rested when I get up
____ I do not feel rested when I get up
____ I have a problem falling asleep
____ I have a problem staying asleep
If you currently have a sleep problem, how often, on the average, is this a problem for you?
____ most nights
____ a few nights per week
____ a few nights per month

How would you describe your energy in the average day? _____

Do you currently have any of the following?
Legal charges/court proceedings: ____ no ___ yes
Problem/excessive gambling: ___ no ___ yes
Excessive spending (so that you are stressed by credit problems): ___no ___ yes
If yes to any of the last 3 questions, please provide a brief description:
_____
_____

Since you last saw Dr. Sethre, have you changed jobs, or had any other significant changes in you employment/finances? __ No __ Yes, if yes, describe briefly:
_____

What is your current relationship status? ___ single ___ married ___ dating ___ in a long-term relationship

If in a relationship, is your partner supportive of you having bariatric surgery?
___ yes ___ no
If you need support after having surgery, who will you turn to? _____
Are you able to work out relationship conflicts to your satisfaction? __ Yes __ No
If no, please describe your concern: _____
_____

(notes)

*Do you have any concerns about meeting any of the pre-surgery expectations that your bariatric program has for you?*
___ No, I feel that I am on track for being cleared for surgery
____ Yes – please describe your concerns: _____
_____

*Are you anxious about having surgery*? ___ no ___ yes
If yes, please explain your concern: _____

*THANK YOU FOR PROVIDING ALL THIS VERY HELPFUL INFORMATION!*
*We will discuss this information during the interview, and you will be able to provide any additional information that will be helpful.*
*Sincerely,*
*Richard Sethre, PsyD, LP*

(notes)