WEIGHT AND LIFESTYLE INVENTORY

(Bariatric Surgery Version)

The Weight and Lifestyle Inventory (WALI) is designed to obtain information about your weight and dieting histories, your eating and exercise habits, and your relationships with family and friends. Please complete the questionnaire carefully and make your best guess when unsure of the answer. You will have an opportunity to review your answers with a member of our professional staff.

Please allow 30-60 minutes to complete this questionnaire. Your answers will help us better identify problem areas and plan your treatment accordingly. The information you provide will become part of your medical record at Penn Medicine and may be shared with members of our treatment team. Thank you for taking the time to complete this questionnaire.

SECTION A: IDENTIFYING INFORMATION

_____
[1] Name

_____ _____ _____lbs. _____ft. _____inches
[2] Date of Birth [3] Age [4] Weight [5] Height

_____
[6] Address

_____ _____ _____/_____ yrs.
[7] Phone: Cell [8] Phone: Home [9] Occupation/# of yrs. at job

_____
[10] Today's Date

[11] Highest year of school completed: (Check one.)

□ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ 12 □ 13 □ 14 □ 15 □ 16 □ Masters □ Doctorate
Middle School High School College

[12] Race (Check all that apply): □ American Indian □ Asian □ African American/Black
□ Pacific Islander □White □ Other: _____

[13] Are you Latino, Hispanic, or of Spanish origin? □ Yes □ No

SECTION B: WEIGHT HISTORY

1. At what age were you first overweight by 10 lbs. or more? _____ yrs. old

2. What has been your highest weight after age 21? _____ lbs. _____ yrs. old at the time

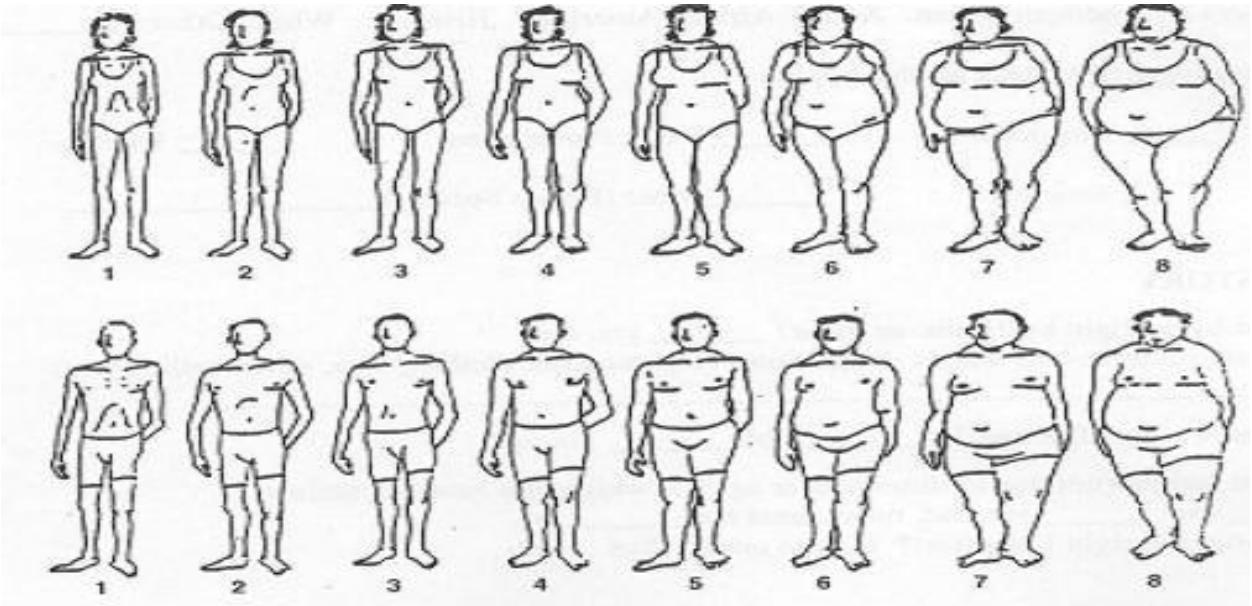
3. What has been your lowest weight (not due to illness) after age 21, which you have maintained for at least 1 year? _____ lbs. _____ yrs. old, maintained for _____ yrs.

For office use:

Interviewer: _____ Date of interview: _____

4. For each time period shown below, please list your maximum weight. If you cannot remember what your maximum weight was, make your best guess and mark "G" (for guess) next to your answer. In addition, please note any events related to your gaining weight during this period. For ages 16 and beyond, please identify the figure, from those shown below, the most resembles your figure at that time. Record the number of the figure.

	AGE	MAXIMUM WEIGHT	FIGURE #	EVENTS RELATED TO WEIGHT GAIN
a.	5-10	_____	_____	_____
b.	11-15	_____	_____	_____
c.	16-20	_____	_____	_____
d.	21-25	_____	_____	_____
e.	26-30	_____	_____	_____
f.	31-35	_____	_____	_____
g.	36-40	_____	_____	_____
h.	41-50	_____	_____	_____
i.	51-60	_____	_____	_____
j.	60-70	_____	_____	_____



SECTION C: FAMILY WEIGHT HISTORY

1. Please indicate the approximate height and weight of your biological mother and father when they were 40-50 years old. Please select from the previous figures the ones that are most similar to your parents' body shapes. If you do not know your biological parents' height and weight, please mark NA (not applicable) in the spaces.

Parent	Height (ft.+in.)	Weight (lbs.)	Current Age (or year of death)	Figure # (from previous page)
a. Mother	_____	_____	_____	_____
b. Father	_____	_____	_____	_____

Please provide the same information for your current spouse or significant other. (Leave blank if not applicable.)

c. Spouse/ Significant Other	_____	_____	_____	_____

2. For each of your grandparents (who are biologically related to you), please check whether they are (were) overweight or obese as an adult. Check "DK" if you don't know.

Your mother's mother: □ Yes □ No □ DK Your father's mother: □ Yes □ No □ DK
Your mother's father: □ Yes □ No □ DK Your father's father: □ Yes □ No □ DK

3. How many brothers do you have (who are biologically related to you)? _____
How many are (were) overweight or obese? _____

4. How many sisters do you have (who are biologically related to you)? _____
How many are (were) overweight or obese? _____

SECTION D: WEIGHT, PREGNANCY, AND MENSTRUAL CYCLE
(*For Women Only)*

1. Have you borne children? (Check one) □ Yes □ No
If yes,
   a. What was your weight at the start of your first pregnancy? _____lbs.
   What was your weight at delivery? _____lbs.
   What was your lowest weight after delivery? _____lbs.

   b. What was your weight at the start of your second pregnancy? _____lbs.
   What was your weight at delivery? _____lbs.
   What was your lowest weight after delivery? _____lbs.

   c. What was your weight at the start of your third pregnancy? _____lbs.
   What was your weight at delivery? _____lbs.
   What was your lowest weight after delivery? _____lbs.

   d. What was your weight at the start of your fourth pregnancy? _____lbs.
   What was your weight at delivery? _____lbs.
   What was your lowest weight after delivery? _____lbs.

Please turn to the last page if you need more space.

2. Do you experience a regular menstrual cycle? □ Yes □ No
   If yes, describe your eating around the time of your menstruation. (Check one)
   □ Eat much less □ Eat less □ No Change □ Eat More □ Eat Much More

SECTION E: WEIGHT LOSS HISTORY

1. Please record your major weight loss efforts, (e.g., diet, exercise, medication, etc.) which resulted in a weight loss of 10 pounds or more. Take time to think over your previous efforts, starting with the first one, whether in childhood or adulthood. You may have difficulty remembering this information at first, but most people can if they take their time. Start with your first weight loss effort and proceed in order. If you have had more than seven efforts on which you lost 10 pounds or more, please list your largest losses.

	Age at time of effort	Weight at start of effort	# lbs. lost	Method used to lose weight
a.	_____	_____	_____	_____
b.	_____	_____	_____	_____
c.	_____	_____	_____	_____
d.	_____	_____	_____	_____
e.	_____	_____	_____	_____
f.	_____	_____	_____	_____
g.	_____	_____	_____	_____

Please turn to the last page if you need additional space.

2. Please indicate the total number of diets on which you have lost 10 pounds or more if you have had more than seven diets. _____

3. Please list any weight loss medications you have used, even if you did not lose 10 pounds or more.

   1. _____ 2. _____ 3. _____

4. Please list any commercial weight loss programs you have used, even if you did not lose 10 pounds or more.

   1. _____ 2. _____ 3. _____

SECTION F: WEIGHT LOSS GOALS

1. How much weight would you like to lose at this time? _____ lbs.

2. This would bring you down to a body weight of _____ lbs.

3. At what age did you last weigh this amount? _____ years

SECTION G: TOBACCO AND ALCOHOL USE

1. Do you currently smoke cigarettes (tobacco)? □ Yes □ No
   If yes,
   a. How many cigarettes do you smoke a day? _____
   b. How many years have you smoked? _____

2. Have you ever smoked cigarettes (tobacco) and stopped? □ Yes □ No
   If yes,
   a. When did you stop smoking? _____
   b. How many cigarettes did you smoke? _____/day
   c. Did you experience any weight gain after stopping smoking? □ Yes □ No
      If yes, how many pounds? _____

3. Do you currently smoke e-cigarettes? □ Yes □ No
   If yes,
   a. How many cartridges do you smoke a day? _____
   b. How many years have you smoked e-cigarettes? _____

4. During the past year:
   a. How many glasses of wine did you typically drink a week? _____
   b. How many bottles of beer did you typically drink a week? _____
   c. How many mixed drinks or liqueurs did you typically have a week? _____

5. Have you ever had a problem with your alcohol consumption? □ Yes □ No
   If yes, please describe the problem and any help you received for it.

   _____

   _____

6. Have any of your immediate family members ever had a problem with alcohol consumption? □ Yes □ No

7. Have you ever had a problem with the use of recreational drugs or prescription medications? □ Yes □ No
   If yes, please describe the problem and any help you received for it.

   _____

   _____

SECTION H: EATING HABITS

1. Please check the behaviors below that are a problem for you and which you believe contribute to weight gain.

□ Overeating at breakfast
□ Overeating at lunch
□ Overeating at dinner
□ Snacking between meals
□ Snacking after dinner
□ Eating because I feel physically hungry
□ Eating because I crave certain foods
□ Continuing to eat because I don't feel full after a meal
□ Eating because I can't stop once I've begun
□ Eating because of the good taste of foods
□ Eating while cooking or preparing food
□ Eating when anxious
□ Eating when tired or bored
□ Eating when stressed or angry
□ Eating when depressed or upset
□ Eating when socializing/celebrating
□ Eating when alone
□ Eating with family or friends
□ Eating at business functions

Please describe any other factors that contribute significantly to your gaining weight.

_____

_____

2. How many days a week do you eat the following meals? Write the number of days in the space and the usual time of each meal.

   a. Breakfast _____ days a week Time: _____ Morning Snack _____ days a week Time: _____

   b. Lunch _____ days a week Time: _____ Afternoon Snack _____ days a week Time: _____

   c. Dinner _____ days a week Time: _____ Evening Snack _____ days a week Time: _____

3. Who prepares meals at your home? _____

4. Please specify the amount (in cups, 8 oz.) of the following fluids you typically consume a day.

_____ skim milk	_____ low-fat milk	_____ whole milk	_____energy drinks	____ other
_____ fruit juice	_____ diet soda	_____ tea	_____coffee	diet drinks
_____ water	_____ regular soda	_____ wine	_____ sports drinks	

5. During a typical week, how many meals do you eat at a fast food restaurant (including drive thru and convenience stores)?

   Breakfast _____ meals a week

   Lunch _____ meals a week

   Dinner _____ meals a week

6. During a typical week, how many meals do you eat a traditional restaurant, coffee shop, cafeteria, or similar establishment?

   Breakfast _____ meals a week

   Lunch _____ meals a week

   Dinner _____ meals a week

SECTION I: FOOD INTAKE RECALL

Please indicate the foods you consume on a typical day.

Meal	Time	Location	Food and Beverages Consumed	Amount
Breakfast				
Morning Snack				
Lunch				
Afternoon Snack				
Dinner				
Evening Snack				

SECTION J: EATING PATTERNS I

The Questionnaire on Eating and Weight Patterns-5 is reprinted here with permission from Yanovski, S.Z., Marcus, M.D., Wadden, T.A. and Walsh, B.T., 2014. (Reprinted in the Int J Eating Disorders 2015.)

1. During the past **three months**, did you ever eat, in a short period of time – for example, a two hour period – what most people would think was an unusually large amount of food? □ Yes □ No

2. During the times when you ate an unusually large amount of food, did you ever feel you could not stop eating or control what or how much you were eating? □ Yes □ No

IF NO, SKIP TO QUESTION 7. Do not complete questions 3-6.

3. During the past **three** months, how often, on average, did you have episodes like this – that is, eating large amounts of food **plus** the feeling that your eating was out of control? (There may have been some weeks when it was not present- just average those in.) (Check one)

□ Less than 1 episode per week
□ 1 episode per week
□ 2-3 episodes per week
□ 4-7 episodes per week
□ 8-13 episodes per week
□ 14 or more episodes per week

4. Did you **usually** have any of the following experiences during these occasions? (Complete all items.)

a. Eating much more rapidly than normal? □ Yes □ No
b. Eating until feeling uncomfortably full? □ Yes □ No
c. Eating large amounts of food when not feeling physically hungry? □ Yes □ No
d. Eating alone because of feeling embarrassed by how much you were eating? □ Yes □ No
e. Feeling disgusted with yourself, depressed, or feeling very guilty afterward? □ Yes □ No

5. Think about a typical episode when you ate this way (that is, when you ate a large amount of food and felt your eating was out of control):

a. What time of day did the episode start?
□ (8 AM to 12 Noon)
□ (12 Noon to 4 PM)
□ (4 PM to 8 PM)
□ (8 PM to 12 Midnight)
□ (12 Midnight to 8 AM)

b. Approximately how long did this episode of eating last? _____ hours _____ minutes

c. As best as you can remember, please list everything you ate and drank during that episode. Please list the foods eaten and liquids consumed during the episode. Be specific- include brand names where possible and amounts or portion sizes as best you can estimate.

FOOD	AMOUNT	BRAND (if possible)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

d. At the time this episode started, how long had it been since you had previously finished eating a meal or snack?

_____ hours _____ minutes

6. In general, during the past **three months**, how upset were you by these episodes (when you ate a large amount of food and felt your eating was out of control)?

□ Not at all □Slightly □ Moderately □ Greatly □ Extremely

7. During the past **three months,** did you ever make yourself vomit in order to avoid gaining weight after episodes of eating like you described (when you ate a large amount of food and felt your eating was out of control)? □ Yes □ No

If Yes: How often, **on average,** was that?
- □ Less than 1 episode per week
- □ 1 episode per week
- □ 2-3 episodes per week
- □ 4-7 episodes per week
- □ 8-13 episodes per week
- □ 14 or more episodes per week

8. During the past **three months**, did you ever take more than the recommended dose of laxatives in order to avoid gaining weight after episodes of eating like you described (when you ate a large amount of food and felt your eating was out of control)?
□ Yes □ No

If Yes: How often, **on average**, was that?
- □ Less than 1 time per week
- □ 1 time per week
- □ 2-3 times per week
- □ 4-5 times per week
- □ 6-7 times per week
- □ 8 or more times per week

9. During the past **three months**, did you ever take more than the recommended dose of diuretics (water pills) in order to avoid gaining weight after episodes of eating like you described (when you ate a large amount of food and felt your eating was out of control)? □ Yes □ No

If Yes: How often, **on average**, was that?
- □ Less than 1 time per week
- □ 1 time per week
- □ 2-3 times per week
- □ 4-5 times per week
- □ 6-7 times per week
- □ 8 or more times per week

10. During the past **three months**, did you ever **fast** – for example, not eat anything at all for at least 24 hours -- in order to avoid gaining weight after episodes of eating like you described (when you ate a large amount of food and felt your eating was out of control)? □ Yes □ No

If Yes: How often, **on average**, was that?
- □ Less than 1 day per week
- □ 1 day per week
- □ 2 days per week
- □ 3 days per week
- □ 4-5 days per week
- □ More than 5 days per week

11. During the past **three months**, did you ever exercise excessively – for example, exercised even though it interfered with important activities or despite being injured – **specifically** in order to avoid gaining weight after episodes of eating like you described (when you ate a large amount of food and felt your eating was out of control)?
□ Yes □ No

If Yes: How often, **on average,** was that?
- □ Less than 1 time per week
- □ 1 time per week
- □ 2-3 times per week
- □ 4-7 times per week
- □ 8-13 times per week
- □ 14 or more times per week

12. During the past **three months**, did you ever take more than the recommended dose of a diet pill in order to avoid gaining weight after episodes of eating like you described (when you ate a large amount of food and felt your eating was out of control)? □ Yes □ No

If Yes: How often, **on average**, was that?

□ Less than 1 time per week
□ 1 time per week
□ 2-3 times per week
□ 4-5 times per week
□ 6-7 times per week
□ 8 or more times per week

13. During the past **three months**, on average, how important has your weight or shape been in how you feel about or evaluate yourself as a person – as compared to other aspects of your life, such as your performance at work or as a parent, or how you get along with other people?

□ Weight and shape were **not very important**
□ Weight and shape **played a part** in how you felt about yourself
□ Weight and shape **were among the main things** that affected how you felt about yourself
□ Weight and shape **were the most important things** that affected how you felt about yourself

14. During the past **three** months, did you ever have episodes during which you felt you could not stop eating or control what or how much you were eating but in which you did ***not*** consume what most people would think was an unusually large amount of food? □ Yes □ No

IF NO, SKIP TO SECTION K. Do not complete questions 15-18.

15. During the past **three** months how often did you have episodes like this -- the feeling that your eating was out of control, but you did ***not*** consume what most people would think was an unusually large amount of food? (There may have been some weeks when this did not happen --just average those in.)

□ Less than 1 episode per week
□ 1 episode per week
□ 2-3 episodes per week
□ 4-7 episodes per week
□ 8-13 episodes per week
□ 14 or more episodes per week

16. Did you **usually** have any of the following experiences during these episodes?

a. Eating much more rapidly than normal?	□ Yes	□ No
b. Eating until feeling uncomfortably full?	□ Yes	□ No
c. Eating large amounts of food when not feeling physically hungry?	□ Yes	□ No
d. Eating alone because of feeling embarrassed by how much you were eating?	□ Yes	□ No
e. Feeling disgusted with yourself, depressed, or feeling very guilty afterward?	□ Yes	□ No

17. Think about a **typical** episode when you ate this way (that is, when you felt you could not stop eating or control what or how much you were eating) but in which you did ***not*** consume an unusually large amount of food):
a. What time of day did the episode start?

□ (8 AM to 12 Noon)
□ (12 Noon to 4 PM)
□ (4 PM to 8 PM)
□ (8 PM to 12 Midnight)
□ (12 Midnight to 8 AM)

b. Approximately how long did this episode of eating last?
____ hours ____ minutes

c. As best you can remember, please list everything you ate and drank during that episode. Please list the foods eaten and liquids consumed during the episode. Be specific – include brand names where possible, and amounts or portion sizes as best you can estimate.

FOOD	AMOUNT	BRAND (if possible)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

d. At the time this episode started, how long had it been since you had previously finished eating a meal or snack?
____ hours ____ minutes

18. In general, during the past **three** months, how **upset** were you by these episodes (that is, when you felt you could not stop eating or control what or how much you were eating but in which you did ***not*** consume an unusually large amount of food)?

□ Not at all
□ Slightly
□ Moderately
□ Greatly
□ Extremely

SECTION K: EATING PATTERNS II
The Night Eating Questionnaire is reprinted with permission of: Allison, K.C., Stunkard, A.J., and Thier, S.L. (2004).

Directions: Please **check one answer** for each question.

1. How hungry are you usually in the morning?
□ Not at all □ A little □ Somewhat □ Moderately □ Very

2. When do you usually eat for the first time?
□ Before 9 AM □ 9:01 to 12 PM □ 12:01 to 3 PM □ 3:01 to 6 PM □ 6:01 or later

3. Do you have cravings or urges to eat snacks after supper, but before bedtime?
□ Not at all □ A little □ Somewhat □ Very much so □ Extremely so

4. How much control do you have over your eating between supper and bedtime?
□ Not at all □ A little □ Some □ Very much □ Complete

5. How much of your daily food intake do you consume *after* suppertime?
□ 0% (none) □ 1-25% (up to a quarter) □ 26-50% (about half)
□ 51-75% (more than half) □ 76-100% (almost all)

6. Are you currently feeling blue or down in the dumps?
□ Not at all □ A little □ Somewhat □ Very much so □ Extremely

7. When you are feeling blue, is your mood lower in the:
□ Early morning □ Late morning □ Afternoon
□ Early evening □ Late evening/nighttime
□ Check here if your mood does not change during the day

8. How often do you have trouble getting to sleep?
□ Never □ Sometimes □ About half the time □ Usually □ Always

9. Other than only to use the bathroom, how often do you get up at least once in the middle of the night?
□ Never □ Less than once a week □ About once a week
□ More than once a week □ Every night

********** ***IF "NEVER" ON #9, PLEASE STOP HERE and Go to Section L**********

10. Do you have cravings or urges to eat snacks when you wake up at night?
□ Not at all □ A little □ Somewhat □ Very much so □ Extremely so

11. Do you need to eat in order to get back to sleep when you awake at night?
□ Not at all □ A little □ Somewhat □ Very much so □ Extremely so

12. When you get up in the middle of the night, how often do you snack?
□ Never □ Sometimes □ About half the time □ Usually □ Always

********** ***IF "NEVER" ON #12, PLEASE SKIP TO #15 **********

12a. *How many times per week* do you usually eat when you wake up at night? _____ times per week

13. When you snack in the middle of the night, how aware are you of your eating?
□ Not at all □ A little □ Somewhat □ Very much so □ Completely

14. How much control do you have over your eating while you are up at night?
□ None at all □ A little □ Some □ Very much □ Complete

15. How long have your difficulties with night eating been going on?
_____ months _____ years

16. Is your night eating upsetting to you?
□ Not at all □ A little □ Somewhat □ Very much so □ Extremely

17. How much has your night eating affected your life?
□ Not at all □ A little □ Somewhat □ Very much so □ Extremely

SECTION L: PHYSICAL ACTIVITY

1. To what extent do you enjoy physical activity? (Check one)
□ Not at all □ Slightly □ Moderately □ Greatly

2. Do you have any physical problems that limit your physical activity? □ Yes □ No

If yes, please describe. _____

3. Please check the types of physical activity that you have engaged in during the past six months.

□ walking outside	□ biking outside	□ tennis/racket sports	□ golf
□ walking (indoors, including treadmill)	□ biking (stationary)	□ swimming	□ dancing
□ jogging/running	□ aerobic class	□ basketball	□ strength training
□ elliptical or other aerobic machine	□ yoga	□ other, Please describe _____	

4. What is your most frequent physical activity? _____
   How many times per week do you engage in this activity? _____ times/week
   How many minutes per week do you engage in this activity? _____ minutes/week

5. How many hours of TV do you watch on an average weekday? _____ hours

6. How many hours of TV do you watch on an average weekend day? _____ hours

7. How many hours of other "screen time" (e.g., computer, videos, games, etc.) do you engage in most days? (Do not count time spent on the computer at work.) _____ hours

8. Approximately how many city blocks or the equivalent do you regularly walk each day? _____ blocks
   (12 blocks = 1 mile)

9. How many flights of stairs do you climb up each day? _____ flights a day (1 flight = 10 steps)

10. Please describe your daily lifestyle activity (i.e., how active you are) by picking any number from 1 to 10 in which 1 = very sedentary and 10 = very active. Your number is: _____

SECTION M: FAMILY AND LIVING ARRANGEMENTS

1. I am currently: (Check one)
   - □ Single
   - □ Married/In committed relationship
   - □ Divorced
   - □ Separated
   - □ Widowed

2. Currently, I am: (Check all that apply)
   - □ living alone
   - □ living with a spouse
   - □ living with a partner/significant other
   - □ living with children
   - □ living with parents/step-parents
   - □ living with other relatives
   - □ living with roommates

3. Please indicate the total number of persons living in your home. _____

4. If you are currently involved in an intimate relationship (spouse/significant other), please answer these questions. What is this person's attitude towards your efforts to lose weight? (Check one)

   - □ strongly supports my efforts
   - □ supports my efforts
   - □ neutral
   - □ opposes my efforts
   - □ strongly opposes my efforts

   Please describe briefly what this person does either to help or hinder your efforts to lose weight.

   _____

   _____

5. How satisfied are you with your overall relationship with this person? (Check one)
   □ very satisfied □ satisfied □ neutral □ dissatisfied □ very dissatisfied

6. Will other people support your efforts to lose weight? □ Yes □ No
   If yes, who will support you? _____
   _____

7. Will other people oppose or undermine your efforts to lose weight? □ Yes □ No
   If yes, who will undermine your efforts? _____
   _____

SECTION N: SELF-PERCEPTIONS

1. How satisfied are you with your current weight? (Check one)

   □ very satisfied
   □ somewhat satisfied
   □ neutral
   □ somewhat dissatisfied
   □ very dissatisfied

2. How satisfied are you with your current overall appearance? (Check one)

   □ very satisfied
   □ somewhat satisfied
   □ neutral
   □ somewhat dissatisfied
   □ very dissatisfied

3. Pick the one sentence that best describes your overall feelings about yourself. "In general, I am…" (Check one)

   □ very happy with who I am
   □ happy with who I am
   □ ok with who I am but have some mixed feelings
   □ unhappy with who I am
   □ very unhappy with who I am

4. "As compared with most people, I think I have…" (Check one)

   □ very good self-esteem
   □ good self-esteem
   □ average self-esteem
   □ poor self-esteem
   □ very poor self-esteem

SECTION O: PSYCHOLOGICAL FACTORS

1. Have you ever had any problems anytime with depression, anxiety, or other emotions? □ Yes □ No

2. Have you ever sought professional assistance for emotional problems? □ Yes □ No
   If yes, specify below.

Problem	Year	Duration (wks.)	Type of Professional Help
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

3. Have you ever been hospitalized for a psychiatric condition? □ Yes □ No
   If yes, describe below.

Problem	Year	Duration (wks.)	Type of Professional Help
_____	_____	_____	_____
_____	_____	_____	_____

4. Have you ever tried to physically harm yourself? □ Yes □ No
   If yes, describe below.

   _____

   _____

5. During the past month, have you felt depressed, sad, or blue much of the time? □ Yes □ No
6. During the past month, have you often felt hopeless about the future? □ Yes □ No
7. During the past month, have you had little interest or pleasure in doing things? □ Yes □ No
8. Have you ever been subjected to physical abuse? □ Yes □ No
9. Have you ever been subjected to sexual abuse? □ Yes □ No

SECTION P: TIMING

1. Please indicate if you are currently experience any greater than usual stress in your life related to the following events. Complete each item by checking the appropriate box.

   a. Work: □ Yes □ No
   b. Health: □ Yes □ No
   c. Relationship with significant other: □ Yes □ No
   d. Activities related to your children: □ Yes □ No
   e. Activities related to your parents: □ Yes □ No
   f. Legal/financial trouble: □ Yes □ No
   g. School: □ Yes □ No
   h. Moving: □ Yes □ No
   i. Other: _____

   Please explain in a sentence any items to which you responded yes:

   _____

   _____

   _____

2. Are you planning any major life changes (e.g., new job, moving, relationship, etc.) during the next 6 months? □ Yes □ No

   If yes, please briefly describe below:

   _____

   _____

   _____

3. How stressful has your life been during the past 6 months? (Check one.)

   □ much less stressful than usual
   □ less stressful than usual
   □ average level of stress
   □ more stressful than usual
   □ much more stressful than usual

4. How stressful do you think that your life will be in the next 6 months, excluding your efforts to lose weight? Pick a number from 1 to 5, in which 1 = much less stressful than usual and 5 = much more stressful than usual. _____

5. Why do you want to lose weight right now, as compared to 1 year ago? What has prompted you to lose weight now?

   _____

   _____

   _____

6. What is the single most important thing that you hope to achieve as a result of losing weight?

   _____

   _____

7. Rate how confident you are that you will be able to significantly change your eating and exercise habits. Pick a number from 1 to 10 in which 1 = not all confident and 10 = extremely confident. Your number is: _____

SECTION Q: PREPARING FOR BARIATRIC SURGERY

1. Have you started separating your meals and drinks by 30 minutes? □ Yes □ No
   Has this been difficult? Describe how you've been doing this.

   _____

   _____

2. Do you understand why we ask you to separate meals and drinks? □ Yes □ No
3. Do you consider yourself a fast or slow eater? □ Fast □ Slow
4. About how long does it take you to eat a meal? (Check one)
   □ less than 20 minutes □ 20-30 minutes □ more than 30 minutes
5. Have you been practicing chewing your food well (until almost pureed consistency)? □ Yes □ No
6. Do you know how many grams of protein per day you are aiming to consume? _____

If having gastric bypass:

7. Do you know what types of food cause dumping syndrome? (Check one)
   □ I don't know □ High fat □ High sugar
8. Do you know how many grams of sugar you are aiming to stay below for each meal or snack? ____

SECTION R: MEDICAL HISTORY

1. Please indicate if you have had any of the medical conditions listed below:

	YES	NO
Heart Disease		
Angina (chest pains)		
Palpitations, heart beats fast or hard		
Stroke, mild stroke (cerebrovascular accident)		
Rheumatic fever		
Heart murmur		
Pacemaker		
Breathing problems (asthma, lung disease)		
High blood pressure		
Anemia		
Back problems		
Joint or bone problems		
Hiatal hernia		
Arthritis		
Gout (elevated uric acid)		
Gallbladder disease		
Thyroid problems		
Kidney disease		
Cancer (specify type)		
Ulcers		
Bowel disease		
Gastric Esophageal Reflux Disease (GERD)		
Liver disease		
Diabetes (type I or II)		
Sleep Apnea		
Bodily pain		
Other (specify)		

2. List all prescription medications you currently take. Please indicate the dosage and frequency (number of times a day) of each medication.

Medication	Dosage	Frequency	Reason for taking
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please indicate your primary care practitioner's name, telephone number, and address here.

Name: _____ Tel: _____

Address: _____

_____

ADDITIONAL INFORMATION (Please use this space to provide any additional information that you think is important to understanding you or your weight problem, as well as the goals you seek.)

_____

_____

_____

_____

_____

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_____