St George's University Hospitals NHS
NHS Foundation Trust

Assessment for (Metabolic) Bariatric Surgery

Weight loss surgery is a highly specialised intervention used for appropriate, selected patients with complex obesity.

To streamline the assessment process, it is **essential for you to complete the following questionnaire**. Whilst the questionnaire may appear long, your responses allow the team to identify individualised areas of support to assure safe, effective, and durable results in the long term. All information that you provide is confidential unless the information suggests there is a significant risk of harm to yourself or others.

Please note that failure to compete and return the questionnaire will result in your case not being processed in a timely manner. Without this questionnaire there may be significant delays to your progression to surgery.

DATE:	St Georges Hospital MRN: NHS number:
First name:	Family name:
Date of birth:	Age:
Home Telephone number:	Mobile number:
Address: Post Code: Borough:	Name of GP:
Your email address:	
Your current: • Height • Weight	Office use: • PHQ • STOP-Bang • BMI
Do you have any of the following health issues: ☐ Pre-Diabetes ☐ Diabetes ☐ Sleep apnoea ☐ High blood pressure ☐ High cholesterol ☐ Heart Disease ☐ Gastric Reflux and taking antiacids ☐ Osteoarthritis ☐ Do you smoke?	What have you tried to lose weight by: ☐ Seeing a dietitian regularly for 3 or more months ☐ Using medication from GP e.g. Orlistat, GLP-1 ☐ Attending a slimming club (face to face or online) If yes, how long did you attend_____ ☐ Using a meal replacement e.g. Slimfast ☐ Participating in NHS '**Better Health Programme'** ☐ NHS '**Digital Weight Management Programme'** ☐ Other: _____ For how long _____ ☐ I have never tried to lose weight

Eating, Activity and Weight Information

Please complete the following sentences or tick the relevant boxes or circle the answer and **answer all questions**.

I normally eat ..... meals a day and ..... snacks a day.

My rate of eating: Slow Average Fast My **portion sizes:** Small Medium Large **(Please circle)**

Typically, I eat ..... portions of fruit a day and ..... portions of vegetable a day.

On average I eat out ☐ never ☐ 1 to 4 times per month ☐ 5 or more times per month

I have takeaways or fast foods ☐ never ☐ 1 to 4 times per month ☐ 5 or more times per month.

I drink fizzy drinks including fizzy water Yes ☐ No ☐ **If yes, how much?**_____

I regularly read food labels: for **Calories** Yes ☐ No ☐ for **Fat** Yes ☐ No ☐ for **Sugar** Yes ☐ No ☐

Most people eat or drink too much occasionally. What triggers your overeating? (Please tick all that apply)

Loneliness ☐	Social occasions ☐	Skipping meals ☐	Stress ☐	Holidays ☐
Partner eating habits ☐	Never feel full ☐	Watching TV ☐	Feeling hungry ☐	Snacking ☐
Cravings ☐	Feeling down ☐	Boredom ☐	Weekends ☐	Alcohol ☐
Work environment ☐	Family pressures ☐	Hectic schedule ☐	No time to cook ☐	

Other…….

What best describes your physical activity at **work**? ☐ **N/A** ☐ **Low** ☐ **Medium** ☐ **High**

Physical activity during the **weekdays** when not working? ☐ **Low** ☐ **Medium** ☐ **High**

Physical activity during the **weekends** when not working? ☐ **Low** ☐ **Medium** ☐ **High**

Average hours you sleep per day _____

What age were you first aware of excess weight? _____

What has been your **heaviest weight** as an adult? _____

What was your **lightest weight** as an adult? _____

How many times have you tried to lose weight? ☐ Never ☐ 1-3 times ☐ 4-6 times ☐ 7 or more

Please note any events/factors that you feel may have caused you to gain weight – e.g. pregnancy, work, life events or medications:

Bariatric Psychology Health

Research has helped us identify patterns of eating behaviour, ways of coping and emotional factors that either help or hinder someone's outcome after bariatric surgery. The following questions will help us advise you about the support you may need to manage any issues and achieve your goals. Please be open and honest when answering these questions – the aim is to make helpful recommendations and provide you with appropriate support.

Have you ever had an eating disorder, either diagnosed or undiagnosed? Yes ☐ No ☐
(This includes anorexia, bulimia, binge eating disorder or any other eating disorder)

If you answered YES to the above question:

- What type of eating disorder did you have?

- When was this a problem?

- What treatment did you receive (if any)?

Do you or have you ever tried to control your weight by 'getting rid of' the foods you have eaten by vomiting or using laxatives? ☐ **Never done this** ☐ **Have done in the past** ☐ **Currently doing this**

When was the last time you did this? _____

1. Do you eat, in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than what most people would eat in a similar period of time? Yes ☐ No ☐

2. If yes, when you eat this way, do you feel a lack of control or you are unable to stop eating? Yes ☐ No ☐

3. During these occasions, do you have any of the following experiences? **Please circle your answers:**

Eating much more rapidly than usual	**Yes**	**No**
Eating until you feel uncomfortably full	**Yes**	**No**
Eating large amounts of food when you didn't feel physically hungry	**Yes**	**No**
Eating alone because you were embarrassed by your eating	**Yes**	**No**
Feeling disgusted in yourself, depressed, or very guilty afterwards	**Yes**	**No**

4. Over a 3 month period, how often would this occur

☐ **Less than one day per week** ☐ **One day a week** ☐ **More than one day a week**

5. Do you find you frequently (more than twice a week) eat in response to your emotions? Yes ☐ No ☐

6. If yes, how many times a week is this occurring? _____

7. Do you feel that eating in response to your emotions contributes significantly to your weight or makes it difficult to lose weight? Yes ☐ No ☐

Have you **ever experienced or been diagnosed** with any of the following mental health difficulties?

	No	I have experienced this in the past (**please indicate when**)	I experience this currently
Depression			
Anxiety disorder (generalised anxiety, social anxiety, specific phobias			
Agoraphobia (a fear of leaving the house)			
Panic attacks			
Obsessive compulsive disorder (OCD)			
Post traumatic stress disorder (PTSD)			
Bipolar affective disorder			
Personality disorder (e.g. BPD, EUPD)			
Psychosis or Schizophrenia			

Over the past 2 weeks how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Feeling nervous, anxious or on edge				
Not being able to stop or control worrying				
Thoughts that I would be better off dead or of hurting yourself in some way				

Made plans to end my life in the last 2 weeks Yes ☐ No ☐

How would you rate your mental health as currently? ☐ **Stable** ☐ **Better than usual** ☐ **Worse than usual**

Do mental health difficulties impact on your eating habits and your weight? Yes ☐ No ☐

If you are currently experiencing or have previously experienced mental health problems, please provide further information. treatment received (medication, talking therapy, inpatient admission}

Have you ever engaged in deliberate self-harm? This includes cutting, overdoses, burning etc. Yes ☐ No ☐

If yes, when was the last time that you did this?

Have you ever made a suicide attempt? Yes ☐ No ☐

If yes, when was this?

Alcohol Information

How often do you have a drink containing alcohol?	**Never**	**Monthly**	**2 to 4 times per month**	**2 to 3 times per week**	**4 or more times per week**
How many units of alcohol do you drink on a typical day when you are drinking?	**0 to 2**	**3 to 4**	**5 to 6**	**7 to 9**	**10+**

1 glass of wine = 2 units 1 pint of beer = 3 units 1 shot of spirits = 1.5 units

How often have you had 6 or more units (if female) or 8 or more (if male) on a single occasion in the last year?	**Never**	**Less than Monthly**	**Monthly**	**Weekly**	**Daily** (or almost)

Do you or have you ever used cocaine, cannabis, or other mind – altering drugs? If yes, when was the last time?	**Yes**	**No**
Have you ever had a problem with alcohol or other drugs? If yes, when was this?	**Yes**	**No**

STOP Bang Questionnaire

	Yes	**No**
Do you *s*nore loudly (louder than talking or loud enough to be heard through closed doors)?		
Do you often feel tired, fatigued, or sleepy during daytime?		
Has anyone *o*bserved you stop breathing during your sleep?		
Do you have or are you being treated for high blood *p*ressure?		
Is your BMI more than 35 kg/m^2?		
Age over 50 years old?		
Is your neck circumference greater than 40 cm?		
Gender – are you male?		

For Office use only: **STOP BANG score =**

Any score of 5 or more, please consider referring to the GP or Respiratory Physician for further OSA evaluation.

Do you currently smoke cigarettes? Yes / No Are you currently considering quitting smoking? Yes / No

If yes, how many cigarettes per day _____

If no, did you smoke in the past and when did you quit? _____

WBIS – M Questionnaire

	Strongly Disagree 1	Disagree 2	Somewhat Disagree 3	Neither Agree nor Disagree 4	Somewhat Agree 5	Agree 6	Strongly Agree 7
1. I am less attractive than most other people because of my weight.	☐	☐	☐	☐	☐	☐	☐
2. I feel anxious about my weight because of what people might think of me.	☐	☐	☐	☐	☐	☐	☐
3. I wish I could drastically change my weight.	☐	☐	☐	☐	☐	☐	☐
4. Whenever I think a lot about my weight, I feel depressed.	☐	☐	☐	☐	☐	☐	☐
5. I hate myself for my weight.	☐	☐	☐	☐	☐	☐	☐
6. My weight is a major way that I judge my value as a person.	☐	☐	☐	☐	☐	☐	☐
7. I don't feel that I deserve to have a really fulfilling social life, because of my weight.	☐	☐	☐	☐	☐	☐	☐
8. I am OK being the weight that I am,	☐	☐	☐	☐	☐	☐	☐
9. Because of my weight, I don't feel like my true self.	☐	☐	☐	☐	☐	☐	☐
10. Because of my weight, I don't understand how anyone attractive would want to date me.	☐	☐	☐	☐	☐	☐	☐

INSTRUCTIONS: Please indicate how much you agree or disagree with each of the following statements.

Rebecca Puhl, PhD, Professor, Human Development & Family Sciences
Deputy Director, Rudd Center for Food Policy & Health, University of Connecticut
(Permission to use granted to SE by R Puhl)

Perceived Stress Scale - 10 items (PSS-10) ©

INSTRUCTIONS:

The questions in this scale ask you about your feelings and thoughts during THE LAST MONTH. In each case, please indicate your response by placing an "X" in the square representing HOW OFTEN you felt or thought a certain way.

		Never 0	Almost Never 1	Sometimes 2	Fairly Often 3	Very Often 4
1.	In the last month, how often have you been upset because of something that happened unexpectedly?	☐	☐	☐	☐	☐
2.	In the last month, how often have you felt that you were unable to control the important things in your life?	☐	☐	☐	☐	☐
3.	In the last month, how often have you felt nervous and "stressed"?	☐	☐	☐	☐	☐
4.	In the last month, how often have you felt confident about your ability to handle your personal problems?	☐	☐	☐	☐	☐
5.	In the last month, how often have you felt that things were going your way?	☐	☐	☐	☐	☐
6.	In the last month, how often have you found that you could cope with all the things that you had to do?	☐	☐	☐	☐	☐
7.	In the last month, how often have you been able to control irritations in your life?	☐	☐	☐	☐	☐
8.	In the last month, how often have you felt that you were on top of things?	☐	☐	☐	☐	☐
9.	In the last month, how often have you been angered because of things that were outside your control?	☐	☐	☐	☐	☐
10.	In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	☐	☐	☐	☐	☐

Thank you for your responses to this questionnaire.

Please review and **ensure you have answered all the questions above. Otherwise, it may mean a delay in** processing your paperwork and **slowing down your progression in the programme. All your answers will be treated confidentially.** However, **some of the responses may be extracted anonymously** to help us audit or evaluate our programme and participant needs.

Your thoughts or comments: if there is anything you would like to add or mention then please do so here.

"Please note that the bariatric surgery service is not a 24 hour service and there may be a lag between completion and screening of bariatric questionnaires. If you feel you are experiencing a mental health crisis please call 111 or your local Mental Health Crisis Service. If you are unable to keep yourself safe please call 999 or go to the nearest A&E".

Please attach a list of your medications and return by post to:-

Bariatric Department, Jasmin Annex, St George's NHS Trust, Blackshaw Road, Tooting, London SW17 0QT

or by email to Hermine.Lewis@stgeorges.nhs.uk