

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 complete 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: <ul style="list-style-type: none"> • Height • Weight | Office use: <ul style="list-style-type: none"> • PHQ • STOP-Bang • BMI |
| Do you have any of the following health issues: <ul style="list-style-type: none"> <input type="checkbox"/> Pre-Diabetes <input type="checkbox"/> Diabetes <input type="checkbox"/> Sleep apnoea <input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart Disease <input type="checkbox"/> Gastric Reflux and taking antiacids <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Do you smoke? | What have you tried to lose weight by: <ul style="list-style-type: none"> <input type="checkbox"/> Seeing a dietitian regularly for 3 or more months <input type="checkbox"/> Using medication from GP e.g. Orlistat, GLP-1 <input type="checkbox"/> Attending a slimming club (face to face or online) If yes, how long did you attend _____ <input type="checkbox"/> Using a meal replacement e.g. Slimfast <input type="checkbox"/> Participating in NHS 'Better Health Programme' <input type="checkbox"/> NHS 'Digital Weight Management Programme' <input type="checkbox"/> Other: _____ For how long _____ <input type="checkbox"/> 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 <input type="checkbox"/> | Social occasions <input type="checkbox"/> | Skipping meals <input type="checkbox"/> | Stress <input type="checkbox"/> | Holidays <input type="checkbox"/> |
| Partner eating habits <input type="checkbox"/> | Never feel full <input type="checkbox"/> | Watching TV <input type="checkbox"/> | Feeling hungry <input type="checkbox"/> | Snacking <input type="checkbox"/> |
| Cravings <input type="checkbox"/> | Feeling down <input type="checkbox"/> | Boredom <input type="checkbox"/> | Weekends <input type="checkbox"/> | Alcohol <input type="checkbox"/> |
| Work environment <input type="checkbox"/> | Family pressures <input type="checkbox"/> | Hectic schedule <input type="checkbox"/> | No time to cook <input type="checkbox"/> | |

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

| | | | | | |
|--|---------------|------------------------------|-----------------------------------|----------------------------------|-------------------------------------|
| | Never | Monthly | 2 to 4 times per month | 2 to 3 times per week | 4 or more times per week |
| How often do you have a drink containing alcohol? | | | | | |
| 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 | | | | | |
| | Never | Less than Monthly | Monthly | Weekly | Daily (or almost) |
| 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? | | | | | |
| Do you or have you ever used cocaine, cannabis, or other mind – altering drugs? | | | | Yes | No |
| If yes, when was the last time? | | | | | |
| Have you ever had a problem with alcohol or other drugs? | | | | Yes | No |
| If yes, when was this? | | | | | |

STOP Bang Questionnaire

| | Yes | No |
|--|-----|----|
| Do you snore 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 observed you stop breathing during your sleep? | | |
| Do you have or are you being treated for high blood pressure? | | |
| 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. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. I feel anxious about my weight because of what people might think of me. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. I wish I could drastically change my weight. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Whenever I think a lot about my weight, I feel depressed. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. I hate myself for my weight. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. My weight is a major way that I judge my value as a person. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. I don't feel that I deserve to have a really fulfilling social life, because of my weight. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. I am OK being the weight that I am, | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Because of my weight, I don't feel like my true self. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Because of my weight, I don't understand how anyone attractive would want to date me. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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

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(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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. In the last month, how often have you felt that you were unable to control the important things in your life? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. In the last month, how often have you felt nervous and “stressed”? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. In the last month, how often have you felt confident about your ability to handle your personal problems? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. In the last month, how often have you felt that things were going your way? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. In the last month, how often have you found that you could cope with all the things that you had to do? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. In the last month, how often have you been able to control irritations in your life? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. In the last month, how often have you felt that you were on top of things? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. In the last month, how often have you been angered because of things that were outside your control? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

