WLS Evaluation Background Information/Schroder

Name _____ Height _____ Weight _____

General Health

CIRCLE ALL THAT ARE TRUE

Diabetes type I Diabetes type II High cholesterol High blood pressure Migraines/Headaches

Neuropathy (burning or needles in feet or hands) Sleep apnea CPAP machine Difficulty sleeping

Asthma COPD Heart disease Cancer/Other major health problem

If not listed above, what other health problem or medical condition do you have? _____

_____

Pain

PAIN (circle if you have pain in any of the following areas): Back Neck Shoulder Hips Knees Feet Hands

PAIN: From 1-10 with 10 as the worst/unbearable, in the last week: usual level ___, highest level ___

Mental / Emotional

CIRCLE ALL THAT ARE TRUE

Do you currently take any antidepressant or antianxiety medication? *Yes* *No*

If yes, what medication(s) _____

In the past five years, have you taken any antidepressant or antianxiety medication? *Yes* *No*

Do you currently see a psychiatrist, psychologist or mental health professional? *Yes* *No*

LIST any current or previous mental health diagnosis or problem (depression, anxiety, bipolar disorder)

_____

_____

Eating / Exercise

Circle Yes or No

Eat overly large portions	*Yes* *No*
Excessive eating between meals / "grazing"	*Yes* *No*
Overeat high-fat food	*Yes* *No*
Overeat high-sugar food	*Yes* *No*
Overeat high-salt food	*Yes* *No*
Excessive time sitting on chair or couch	*Yes* *No*

In the last month, have you

Walked more than 100 feet at one time	*Yes* *No*
Ridden a bike or exercise bike	*Yes* *No*
Been to a gym or used a swimming pool to get exercise	*Yes* *No*