Blossom Bariatrics Thomas Umbach, MD BLOSSOM MEDICAL GROUP

Psychological Evaluation

Patient Information

Name: _____ DOB: _____ Current Age: _____ ❑ Female ❑ Male

1. Martial Status (fill in only one):
   - ❑ Never married
   - ❑ Married
   - ❑ Divorced or widowed & presently remarried
   - ❑ Monogamous Relationship. living with partner (but not married)
   - ❑ Monogamous Relationship, not living with partner
   - ❑ Divorced and not presently married
   - ❑ Widowed and not presently married

2. *What is your primary role (fill in only one):*
   - ❑ Wage earner, full-time
   - ❑ Wage earner, part-time
   - ❑ Student, full-time
   - ❑ Student, part-time
   - ❑ Homemaker
   - ❑ Unemployed
   - ❑ Other (specify): _____

Weight History

1. Current Weight: _____ 2. Current Height:_____ 3. I would like to weigh: _____

4. Highest Weight (non-pregnancy) last 10 years: _____ 5. Lowest Weight last 10 years: _____

6. At your current weight, do you feel that you are:
   - ❑ Extremely thin
   - ❑ Moderately thin
   - ❑ Slightly thin
   - ❑ Normal weight
   - ❑ Slightly overweight
   - ❑ Moderately overweight
   - ❑ Extremely overweight

7. How much do you fear gaining weight?
   - ❑ Not at all
   - ❑ Slightly
   - ❑ Moderately
   - ❑ Very much
   - ❑ Extremely

8. How dissatisfied are you with the way your body is proportioned?
   - ❑ Not at all dissatisfied
   - ❑ Slightly dissatisfied
   - ❑ Moderately dissatisfied
   - ❑ Very dissatisfied
   - ❑ Extremely dissatisfied

9. How important is your weight & shape in affecting how you feel about yourself as a person?
   - ❑ Not at all important
   - ❑ Slightly important
   - ❑ Moderately important
   - ❑ Very important
   - ❑ Extremely important

10. How fat do you feel? currently
   - ❑ Not at all fat
   - ❑ Slightly fat
   - ❑ Fat
   - ❑ Very fat
   - ❑ Extremely fat

11. Please indicate on the scales below how you feel about different areas of you body. (Fill in the box of the best response for each body part.)

	face	*arms*	*shoulders*	*breasts*	*stomach*	*waist*	*hips*	*buttocks*	*thighs*
Extremely positive	❑	❑	❑	❑	❑	❑	❑	❑	❑
Moderately positive	❑	❑	❑	❑	❑	❑	❑	❑	❑
Slightly positive	❑	❑	❑	❑	❑	❑	❑	❑	❑
Neutral	❑	❑	❑	❑	❑	❑	❑	❑	❑
Slightly negative	❑	❑	❑	❑	❑	❑	❑	❑	❑
Moderately negative	❑	❑	❑	❑	❑	❑	❑	❑	❑
Extremely negative	❑	❑	❑	❑	❑	❑	❑	❑	❑

12. On the average, how often do you weigh yourself?
   - ❑ Never
   - ❑ Less than monthly
   - ❑ Monthly
   - ❑ Several times a month
   - ❑ Weekly
   - ❑ Several times a week
   - ❑ Daily
   - ❑ 2 or 3 times a day
   - ❑ 4 or 5 times a day
   - ❑ More than 5 times a day

Dieting Behavior

1. On the average, how many meals do you eat each day?

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5+

2. On the average, how many snacks do you eat each day?

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5+

3. On the average, how many days a week do you eat the following meals?

Breakfast	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7
Lunch	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7
Dinner	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7

4. Do you try to avoid certain foods in order to influence your shape or weight?

❑ No

❑ Yes. (If yes, what?): _____

5. Have you ever been on a diet, restricted your food intake, and/or reduced the amounts or types of food eat to control your weight?

❑ No (If No, go to Binge Eating Behavior)

❑ Yes

6. At what age did you first begin to diet, restrict your food intake, and/or reduce the amount or types of food eaten to control your weight?

_____ years old

7. At what age did you first begin to diet, restrict your food intake, and/or reduce the amount or types of food eaten to lose weight?

_____ years old

8. Over the last year, how often have you begun a diet that lasted for more than 3 days?

_____ times

9. Over the last year, how often have you begun a diet that lasted for 3 days or less?

_____ times

10. Indicate your preferred ways of dieting (check all that apply):

❑ Skipping meals
❑ Completely fast for 24 hours or more
❑ Restrict carbohydrates
❑ Reduce fats
❑ Reduce portion size
❑ Exercise more
❑ Reduce calories
❑ Other: _____

11. In which of the following treatments or type of treatment for eating or wight problems have you participated?

Supervised Diets:	***Yes***	***No***	***If yes, ages used***	***How many pounds did you lose/gain?***
Weight Watchers ®	❑	❑		
Jenny Craig ®	❑	❑		
Nutrasystems ®	❑	❑		
Optifast ®	❑	❑		
Procal ®	❑	❑		
Nutramed ®	❑	❑		
Liquid protein diet	❑	❑		
Other:	❑	❑		

Self-Help Groups	***Yes***	***No***	***If yes, ages used***	***How many pounds did you lose/gain?***
Bulimia Anonymous	❑	❑		
Overeaters Anonymous	❑	❑		
Anorexics Anonymous	❑	❑		
Other:	❑	❑		

Medication for Obesity	***Yes***	***No***	***If yes, ages used***	***How many pounds did you lose/gain?***
Phentermine	❑	❑		

Medication for Obesity	*Yes*	*No*	*If yes, ages used*	*How many pounds did you lose/gain?*
Fenfluramine	❑	❑		
Xenical (Orlistat ®)	❑	❑		
Sibutramin (Meridia ®)	❑	❑		
Topiramate (Topomax ®)	❑	❑		
Wellbutrin (Buproprion ®)	❑	❑		
Over the counter diet pills	❑	❑		
Other medication treatment	❑	❑		
Human Chorionic Gonadotropin	❑	❑		
Others:	❑	❑		

Medication for Eating Problems/Weight Problems	*Yes*	*No*	*If yes, ages used*	*How many pounds did you lose/gain?*
Fluoxetine (Prozac ®)	❑	❑		
Desipramine (Norpramin ®)	❑	❑		
Paroxetine HCl (Paxil ®)	❑	❑		
Sertraline HCl (Zoloft ®)	❑	❑		
Citalopram (Celexa ®)	❑	❑		
Fluvoxamine (Luvox ®)	❑	❑		
Naltrexone (Trexan ®)	❑	❑		
Escitalopram (Lexapro ®)	❑	❑		
Quetiapine (Seroquel ®)	❑	❑		
Olanzapine (Zyprexa ®)	❑	❑		
Risperidone (Risperidol ®)	❑	❑		
Other:	❑	❑		

Psychotherapy for Eating Problems, Weight Loss or Weight Gain	*Yes*	*No*	*If yes, ages used*	*How many pounds did you lose/gain?*
Behavior Modification	❑	❑		
Individual Psychotherapy	❑	❑		
Group Psychotherapy	❑	❑		
Hypnosis	❑	❑		
Other:	❑	❑		

Psychotherapy for Eating Disorders	*Yes*	*No*	*If yes, ages used*	*How many pounds did you lose/gain?*
Individual Cognitive Behavioral	❑	❑		
Group Cognitive Behavioral	❑	❑		
Interpersonal Psychotherapy	❑	❑		

Psychotherapy for Eating Disorders	*Yes*	*No*	*If yes, ages used*	*How many pounds did you lose/gain?*
Nutritional Counseling	❑	❑		
Other:	❑	❑		

Surgical Procedures	*Yes*	*No*	*If yes, ages used*	*How many pounds did you lose/gain?*
Liposuction	❑	❑		
Gastric Bypass	❑	❑		
Gastric Banding	❑	❑		
Other Intestinal Surgery	❑	❑		
Gastric Balloon / “Bubble”	❑	❑		
Other:	❑	❑		

12. Please record your major diets (if not already listed above):

Type of Diet	*If yes, ages used*	*How many pounds did you lose/gain?*

13. Have you ever had significant physical or emotional symptoms while attempting to lose weight or after losing weight?
    ❑ Yes ❑ No

If Yes, describe your symptoms, how long they lasted, if they made you stop your weight loss program, and if they made you seek professional help.

Problem	*Year*	*Duration (weeks)*	*Stopped weight loss program?* *Yes*	*No*	*Type of professional help, if any*
			❑	❑	
			❑	❑	
			❑	❑	
			❑	❑	
			❑	❑	

Binge Eating Behavior

1. Have you ever had an episode of binge eating characterized by:

a. Eating, in a discrete period of time (e.g. within any two hour period), an amount of food that is definitely larger than most people eat in a similar period of time? ❑ Yes ❑ No

b. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)? ❑ Yes ❑ No

2. Please indicate on the scales below how characteristic the following symptoms are or were of your binge eating.

	never	*rarely*	*sometimes*	*often*	*always*
a. Feeling that I can't stop eating or control what or how much I eat	❑	❑	❑	❑	❑
b. Eating much more rapidly than usual	❑	❑	❑	❑	❑
c. Eating until I feel uncomfortably full	❑	❑	❑	❑	❑
d. Eating large amounts of food when not feeling physically hungry	❑	❑	❑	❑	❑
e. Eating alone because I am embarrassed by how much I am eating	❑	❑	❑	❑	❑
f. Feeling disgusted with myself, depressed, or very guilty after overeating	❑	❑	❑	❑	❑
g. Feeling very distressed about binge eating	❑	❑	❑	❑	❑

3. How old where you when you began binge eating?

_____ years old

4. When did binge eating start to occur on a regular basis, on average at least 2 times a week?

_____ years old

5. What is the total duration of time you had a problem with binge eating (whether or not you are binge eating now)?

_____ years old

Weight Control Behavior

1. Have you ever self-induced vomiting after eating in order to get rid of the the food eaten?

❑ Yes ❑ No

2. How old were you when you induced vomiting for the first time?

_____ years old

3. How long did you self-induce in vomiting?

Days: _____ Months: _____ Years: _____

4. Have you ever taken yrup of Ipecac® to control your weight?

❑ Yes ❑ No

5. How old where you when you first took Ipecac® for the first time?

_____ years old

6. How long did you use Ipecac® to control your weight?

Days: _____ Months: _____ Years: _____

7. Have you ever used laxatives to control your weight or of food"? weight control?

❑ Yes ❑ No

8. How old where you when you first took laxatives for "get rid

_____ years old

9. How old were you when you first took laxatives for weight control (on a regular basis on average at least two times each week)?

_____ years old

10. How long did you use laxatives for weight control?

Days: _____ Months: _____ Years: _____

11. What type & amounts of laxatives have you used? (Indicate all types that apply and the maximum number used per day)?

			Maximum Number per Day										
Laxatives:	Yes	No	1	2	3	4	5	6	7	8	9	10	10+
Ex-Lax®	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Correctol®	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Metamucil®	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Colace®	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Dulcolax®	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Phillips Milk of Magnesia®	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Senokot®	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Perdiem®	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Fleet®	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Other (specify):													
_____	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑

12. Have you ever used diuretics (water pills) to control your weight?

❑ Yes ❑ No *(If No, please go to question 17.)*

13. How old were you when you first took diuretics for weight control?

_____ years old

14. How old were you when you first took diuretics for weight control (on a regular basis, on average at least two times each week?

_____ years old

15. How long did you use diuretics for weight control?

Days: _____ Months: _____ Years: _____

16. What type and amount of diuretics have you used? (Indicate all that apply and the maximum number used per day.)

			Maximum Number per Day										
Diuretics:	Yes	No	1	2	3	4	5	6	7	8	9	10	10+
Aqua-Ban®	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Diurex®	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Midol®	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Pamprin®	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Other (specify):													
_____	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Prescription Diuretics:													
_____	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
_____	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
_____	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑

17. Have you ever used diet pills to control your weight?

❑ Yes ❑ No *(If No, please go to question 21.)*

18. How old were you when your first used diet pills for weight control?

_____ years old

19. How long did you use diet pills to control your weight?

Days: _____ Months: _____ Years: _____

20. What types and amounts of diet pills have you used **within the last month**? (Indicate all that apply and the maximum number per day)

			Maximum Number per Day										
Over the Counter Diet Pills:	Yes	No	1	2	3	4	5	6	7	8	9	10	10+
Dexatrim®	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Dietac®	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Acutrim®	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Protrim®	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Ma Huang	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Ephedrine	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Chromium	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Guarana Seed	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Garcinia Cambogia	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Caffeine	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Other (specify):													
	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Prescription Diet Pills:													
	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑

21. During the **last month**, what is the average frequency that you have engaged in the following behaviors? (Please check one box for each behavior)

	Never	Once a Month or Less	Several Times a Month	Once a Week	Twice a Week	Three to Six Times a Week	Once a Day	More Than Once a Day
Binge Eating (as defined on page 5.)	❑	❑	❑	❑	❑	❑	❑	❑
Vomiting	❑	❑	❑	❑	❑	❑	❑	❑
Laxative use to control weight	❑	❑	❑	❑	❑	❑	❑	❑
Use of diet pills	❑	❑	❑	❑	❑	❑	❑	❑
Use of diuretics	❑	❑	❑	❑	❑	❑	❑	❑
Use of enemas	❑	❑	❑	❑	❑	❑	❑	❑
Use of Ipecac Syrup	❑	❑	❑	❑	❑	❑	❑	❑
Exercise to control weight	❑	❑	❑	❑	❑	❑	❑	❑
Fasting (skipping meals for entire day)	❑	❑	❑	❑	❑	❑	❑	❑
Skipping meals	❑	❑	❑	❑	❑	❑	❑	❑
Eating meals low in calories and/or fat	❑	❑	❑	❑	❑	❑	❑	❑
Chewing and spitting out food	❑	❑	❑	❑	❑	❑	❑	❑
Rumination (vomit food into mouth, chew and re-swallow	❑	❑	❑	❑	❑	❑	❑	❑
Saunas to control weight	❑	❑	❑	❑	❑	❑	❑	❑
Herbal products (“fat burners”)	❑	❑	❑	❑	❑	❑	❑	❑

22. During any one **month period**, what is the **highest** frequency that you have engaged in the following behaviors? (Please check one box for each behavior)

	Never	Once a Month or Less	Several Times a Month	Once a Week	Twice a Week	Three to Six Times a Week	Once a Day	More Than Once a Day
Binge Eating (as defined on page 5.)	❑	❑	❑	❑	❑	❑	❑	❑
Vomiting	❑	❑	❑	❑	❑	❑	❑	❑
Laxative use to control weight	❑	❑	❑	❑	❑	❑	❑	❑
Use of diet pills	❑	❑	❑	❑	❑	❑	❑	❑
Use of diuretics	❑	❑	❑	❑	❑	❑	❑	❑
Use of enemas	❑	❑	❑	❑	❑	❑	❑	❑
Use of Ipecac Syrup	❑	❑	❑	❑	❑	❑	❑	❑
Exercise to control weight	❑	❑	❑	❑	❑	❑	❑	❑
Fasting (skipping meals for entire day)	❑	❑	❑	❑	❑	❑	❑	❑
Skipping meals	❑	❑	❑	❑	❑	❑	❑	❑
Eating meals low in calories and/or fat	❑	❑	❑	❑	❑	❑	❑	❑
Chewing and spitting out food	❑	❑	❑	❑	❑	❑	❑	❑
Rumination (vomit food into mouth, chew and re-swallow	❑	❑	❑	❑	❑	❑	❑	❑
Saunas to control weight	❑	❑	❑	❑	❑	❑	❑	❑
Herbal products (“fat burners”)	❑	❑	❑	❑	❑	❑	❑	❑

Exercise

1. How frequently do you exercise?
   - ❑ Not at all
   - ❑ Once per month or less
   - ❑ Several times per month
   - ❑ Once per week
   - ❑ Several times per week
   - ❑ Once per day
   - ❑ Several times a day

2. If you exercise, how long do you usually exercise each time?
   - ❑ Less than 15 minutes
   - ❑ 15-30 minutes
   - ❑ 31-60 minutes
   - ❑ 61-120 minutes
   - ❑ More than 120 minutes

3. If you exercise, please indicate the types of exercise you do (fill in all that apply).
   - ❑ Biking
   - ❑ Swimming
   - ❑ Calisthenics
   - ❑ Stationary Bike
   - ❑ Walking
   - ❑ Weight Training
   - ❑ In-line Skating
   - ❑ Other: _____
   - ❑ Running
   - ❑ Aerobics
   - ❑ Treadmill

Menstrual History

1. Age of onset of menses: _____ years old

2. Have you ever had periods of time when you stopped, menstruating for three months or more (which were unrelated to pregnancy?
   ❑ Yes ❑ No If Yes, number of times: _____

3. Did weight loss ever cause irregularities of your cycle?
   ❑ Yes ❑ No

4. Are you on birth control pills? ❑ Yes ❑ No

5. Are you on hormone replacement? ❑ Yes ❑ No

5. Are you post menopausal? ❑ Yes ❑ No

6. Please indicate when during your cycle you feel most vulnerable to binge eating. Please fill in the single best response.
   - ❑ I do not binge eat during menstruation
   - ❑ 11 - 14 days prior to menstruation
   - ❑ 7 - 10 days prior to menstruation
   - ❑ 3 - 6 days prior to menstruation
   - ❑ 1 - 2 days prior to menstruation
   - ❑ After menstruation onset
   - ❑ No particular time

7. Do you crave particular foods (have a desire or urge to consume a specific food item or drink) for the <u>few days prior to</u> menstruation? menstruation?
   ❑ Yes ❑ No If Yes, what foods do you crave?

   _____

   _____

8. Do you crave particular foods (have a desire or urge to consume a specific food item or drink) <u>during</u> your
   ❑ Yes ❑ No If Yes, what foods do you crave?

   _____

   _____

9. Marriage & Pregnancy:

	Yes	*No*	*Does Not Apply*
a. Did problems with weight and/or binge eating begin before you were married?	❑	❑	❑
b. Did problems with weight and/or binge eating begin after you were married?	❑	❑	❑
c. Did problems with weight and/or binge eating begin before your first pregnancy?	❑	❑	❑
d. Did problems with weight and/or binge eating begin after your first pregnancy?	❑	❑	❑

10. Do you have children?

❑ Yes ❑ No (If No, skip to section: *History of Abuse*)

a. For your FIRST child, what was your...

...weight at the start of your pregnancy?	...weight at delivery?	...lowest weight in the first year after delivery?
_____ pounds	_____ pounds	_____ pounds

b. For your SECOND child, what was your...

...weight at the start of your pregnancy?	...weight at delivery?	...lowest weight in the first year after delivery?
_____ pounds	_____ pounds	_____ pounds

c. For your THIRD child, what was your...

...weight at the start of your pregnancy?	...weight at delivery?	...lowest weight in the first year after delivery?
_____ pounds	_____ pounds	_____ pounds

d. For your FOURTH child, what was your...

...weight at the start of your pregnancy?	...weight at delivery?	...lowest weight in the first year after delivery?
_____ pounds	_____ pounds	_____ pounds

History of Abuse

1. Before you where 18, did any of the following happen to you?

	Yes	No
Someone constantly criticized you and blamed you for minor things.	❑	❑
Someone physically beat you (hit you, slapped you, threw something at you, pushed you).	❑	❑
Someone threatened to hurt or kill you, or do something sexual to you.	❑	❑
Someone threatened to abandon or leave you.	❑	❑
You watched one parent physically beat (hit, slap) the other parent.	❑	❑
Someone from your family forced you to have sexual relationships (unwanted touching fondling, sexual kissing, sexual intercourse).	❑	❑
Some outside your family forced you to have sexual relationships (unwanted touching fondling sexual kissing, sexual intercourse).	❑	❑

2. After you where 18, did any of the following happen to you?

	Yes	No
Someone constantly criticized you and blamed you for minor things.	❑	❑
Someone physically beat you (hit you, slapped you, threw something at you, pushed you).	❑	❑
Someone threatened to hurt or kill you, or do something sexual to you.	❑	❑
Someone threatened to abandon or leave you.	❑	❑
You watched one parent physically beat (hit, slap) the other parent.	❑	❑
Someone from your family forced you to have sexual relationships (unwanted touching fondling, sexual kissing, sexual intercourse).	❑	❑
Some outside your family forced you to have sexual relationships (unwanted touching fondling sexual kissing, sexual intercourse).	❑	❑

Psychiatric History

1. Have you ever been hospitalized for psychiatric problems?
   ❑ Yes ❑ No (If ***Yes***, Please complete the section below.)

Hospital Name City & State	***What Year(s)***	***Diagnosis or Problem you were having***	***Treatment You Received***	***Was This Helpful?*** ***Yes***	***No***
				❑	❑
				❑	❑
				❑	❑
				❑	❑
				❑	❑

2. Have you ever been treat out of the hospital for psychiatric problems?
   ❑ Yes ❑ No (If ***Yes***, Please complete the section below.)

Doctor or Therapist's City & State	***What Year(s)***	***Diagnosis or Problem you were having***	***Treatment You Received***	***Was This Helpful?*** ***Yes***	***No***
				❑	❑
				❑	❑
				❑	❑
				❑	❑
				❑	❑

3. Complete the following information for any of the following types of medications you are now taking or have ever taken:

Mood Stabilizers		***Took Previously***	***Currently Taking***	***Current Dosage***	***If taking currently, for what problem?***
Lithobid®	Lithium®	❑	❑		
Depakote®	Sodium Valproate®	❑	❑		
Tegretol®	(Carbamazepine)	❑	❑		
Topomax®	(Topiramate)	❑	❑		
Lamictal®	(Lamotrigine)	❑	❑		
Other:		❑	❑		
Other:		❑	❑		
Other:		❑	❑		
Other:		❑	❑		

Antidepressants		Took Previously	Currently Taking	Current Dosage	If taking currently, for what problem?
Prozac®	(Fluxetine)	❑	❑		
Zoloft®	(Sertaline)	❑	❑		
Paxil®	(Paroxetine)	❑	❑		
Luvox®	(Fluvoxamine)	❑	❑		
Celexa®	(Citalopram)	❑	❑		
Effexor®	(Venlafaxine)	❑	❑		
Wellbutrin®	(Bupropion)	❑	❑		
Elavil®	(Amitriptyline)	❑	❑		
Tofranil®	(Imipramine)	❑	❑		
Sinequan®	(Doxepin)	❑	❑		
Norpramin®	(Desipramine)	❑	❑		
Vivactil®	(Protriptyline)	❑	❑		
Desyrel®	(Trazodone)	❑	❑		
Parnate®	(Tranylcypromine)	❑	❑		
Nardil®	(Phenezine)	❑	❑		
Anafranil®	(Clomipramine)	❑	❑		
Remeron®	(Mirtazapine)	❑	❑		
Serzone®	(Nefazodone)	❑	❑		
St. John's Wort		❑	❑		
Lexapro®	(Escitalopram)	❑	❑		

Major Tranquilizers		Took Previously	Currently Taking	Current Dosage	If taking currently, for what problem?
Clozaril®	(Clozapine)	❑	❑		
Zyprexa®	(Olanzepine)	❑	❑		
Risperdal®	(Risperidone)	❑	❑		
Haldol®	(Haloperidol)	❑	❑		
Navane®	(Thiothixene)	❑	❑		
Trilafon®	(Perphenazine)	❑	❑		
Thorazine®	(Chlorpromazine)	❑	❑		
Stelazine®	(Trifluoperazine)	❑	❑		
Prolixin®	(Fluphenazine)	❑	❑		
Orap®	(Pimozide)	❑	❑		
Moban®	(Molindone)	❑	❑		
Loxitane®	(Loxapine)	❑	❑		
Seroquil®	(Quetiapine)	❑	❑		
Mellaril®	(Thioridazine)	❑	❑		
Geodon®	(Ziprasidone)	❑	❑		
Abilify®	(Aripiprozole)	❑	❑		

Minor Tranquilizers		Took Previously	Currently Taking	Current Dosage	If taking currently, for what problem?
Valium®	(Diazepam)	❑	❑		
Librium®	(Chlordiazepoxide)	❑	❑		
Serax®	(Oxazepam)	❑	❑		
Halcion®	(Triazolam)	❑	❑		
Tranxene®	(Clorazepate)	❑	❑		
Ambien®	(Zolpidem)	❑	❑		
Klonopin®	(Clonazepam)	❑	❑		
Ativan®	(Lorazepam)	❑	❑		
BuSpar®	(Buspirone)	❑	❑		
Dalmane®	(Flurazepam)	❑	❑		
Xanax®	(Alprazolam)	❑	❑		
Sonata®	(Zaleplon)	❑	❑		

Chemical Use History

1. In the last six months, how often have you taken these drugs?

	Never	Less Than Monthly	About Once a Month	Several Times a Month	About Once a Week	Several Times a Week	Daily	Several TImes a Day
Alcohol	❑	❑	❑	❑	❑	❑	❑	❑
Stimulants (Amphetamines, Uppers, Crank, Speed)	❑	❑	❑	❑	❑	❑	❑	❑
Diet Pills	❑	❑	❑	❑	❑	❑	❑	❑
Sedatives (Barbiturates, Sleeping Pills, Valium®, Librium®, Downers)	❑	❑	❑	❑	❑	❑	❑	❑
Marijuana/Hashish	❑	❑	❑	❑	❑	❑	❑	❑
Hallucinogens (LSD, Mescaline, Mushrooms, Extasy)	❑	❑	❑	❑	❑	❑	❑	❑
Opiates (Heroin, Morphine, Opium)	❑	❑	❑	❑	❑	❑	❑	❑
Cocaine/Crack	❑	❑	❑	❑	❑	❑	❑	❑
PCP (Angel Dust, Phencyclidine)	❑	❑	❑	❑	❑	❑	❑	❑
Inhalants (Glue, Gasoline, etc.)	❑	❑	❑	❑	❑	❑	❑	❑
Caffeine Pills (No Doz®, Vivarin®, etc.)	❑	❑	❑	❑	❑	❑	❑	❑
Other:	❑	❑	❑	❑	❑	❑	❑	❑
Other:	❑	❑	❑	❑	❑	❑	❑	❑

2. What is the most you have used any of these drugs during a one-month period (month of heaviest use)?

Example: If you used sleeping pills about once a month many years ago, but not at all now, you would fill in the box under "About Once a Month" on the line "Sedatives"

	Never	Less Than Monthly	About Once a Month	Several Times a Month	About Once a Week	Several Times a Week	Daily	Several TImes a Day
Alcohol	❑	❑	❑	❑	❑	❑	❑	❑
Stimulants (Amphetamines, Uppers, Crank, Speed)	❑	❑	❑	❑	❑	❑	❑	❑
Diet Pills	❑	❑	❑	❑	❑	❑	❑	❑

(Continued)

Sedatives (Barbiturates, Sleeping Pills, Valium®, Librium®, Downers)	❑	❑	❑	❑	❑	❑	❑	❑
Marijuana/Hashish	❑	❑	❑	❑	❑	❑	❑	❑
Hallucinogens (LSD, Mescaline, Mushrooms, Extasy)	❑	❑	❑	❑	❑	❑	❑	❑
Opiates (Heroin, Morphine, Opium)	❑	❑	❑	❑	❑	❑	❑	❑
Cocaine/Crack	❑	❑	❑	❑	❑	❑	❑	❑
PCP (Angel Dust, Phencyclidine)	❑	❑	❑	❑	❑	❑	❑	❑
Inhalants (Glue, Gasoline, etc.)	❑	❑	❑	❑	❑	❑	❑	❑
Caffeine Pills (No Doz®, Vivarin®, etc.)	❑	❑	❑	❑	❑	❑	❑	❑
Other:	❑	❑	❑	❑	❑	❑	❑	❑
Other:	❑	❑	❑	❑	❑	❑	❑	❑

3. Have you ever had any of the following problems because of your alcohol or drug use? (If Yes, please specify.)

Drinking and driving when unsafe?	❑ Yes... When? ❑ No	❑ More than 6 months ago ❑ During the past 6 months ❑ Both
Medical Problem?	❑ Yes... When? ❑ No	❑ More than 6 months ago ❑ During the past 6 months ❑ Both
Problems at work or school?	❑ Yes... When? ❑ No	❑ More than 6 months ago ❑ During the past 6 months ❑ Both
An arrest?	❑ Yes... When? ❑ No	❑ More than 6 months ago ❑ During the past 6 months ❑ Both
Family trouble?	❑ Yes... When? ❑ No	❑ More than 6 months ago ❑ During the past 6 months ❑ Both

4. Have you ever smoked cigarettes?
   - ❑ Yes
   - ❑ No

   What was the most you ever smoked?
   - ❑ Only occasionally
   - ❑ Less than a pack per day
   - ❑ About one pack per day
   - ❑ One to two packs per day
   - ❑ About two packs per day
   - ❑ More than two packs per day

   If you are smoking now, how much do you smoke?
   - ❑ Only occasionally
   - ❑ Less than a pack per day
   - ❑ About one pack per day
   - ❑ One to two packs per day
   - ❑ About two packs per day
   - ❑ More than two packs per day

5. Do you drink coffee?
   - ❑ Yes
   - ❑ No

   On the average, how many cups of caffeinated coffee do you drink per day?
   - ❑ Less than 1
   - ❑ 1 cup
   - ❑ 2 cups
   - ❑ 3 cups
   - ❑ 4 cups
   - ❑ 5 cups
   - ❑ 6-10 cups
   - ❑ 10+ cups

   On the average, how many cups of decaffeinated coffee do you drink per day?
   - ❑ Less than 1
   - ❑ 1 cup
   - ❑ 2 cups
   - ❑ 3 cups
   - ❑ 4 cups
   - ❑ 5 cups
   - ❑ 6-10 cups
   - ❑ 10+ cups

6. Do you drink tea?
   - ❑ Yes
   - ❑ No

   On the average, how many cups of caffeinated tea do you drink per day?
   - ❑ Less than 1
   - ❑ 1 cup
   - ❑ 2 cups
   - ❑ 3 cups
   - ❑ 4 cups
   - ❑ 5 cups
   - ❑ 6-10 cups
   - ❑ 10+ cups

   On the average, how many cups of decaffeinated tea do you drink per day?
   - ❑ Less than 1
   - ❑ 1 cup
   - ❑ 2 cups
   - ❑ 3 cups
   - ❑ 4 cups
   - ❑ 5 cups
   - ❑ 6-10 cups
   - ❑ 10+ cups

7. Do you drink sodas?
   - ❑ Yes
   - ❑ No

   On the average, how many cans/glasses caffeinated sodas do you drink per day?
   - ❑ Less than 1
   - ❑ 1 cup
   - ❑ 2 cups
   - ❑ 3 cups
   - ❑ 4 cups
   - ❑ 5 cups
   - ❑ 6-10 cups
   - ❑ 10+ cups

   On the average, how many cans/glasses decaffeinated sodas do you drink per day?
   - ❑ Less than 1
   - ❑ 1 cup
   - ❑ 2 cups
   - ❑ 3 cups
   - ❑ 4 cups
   - ❑ 5 cups
   - ❑ 6-10 cups
   - ❑ 10+ cups

Social History

Highest level achieved in school (choose one):

- ❑ 8th grade or less
- ❑ Some high school
- ❑ High school graduate
- ❑ Trade or technical school
- ❑ Some college
- ❑ College graduate
- ❑ Graduate study
- ❑ Graduate degree
- ❑ Post-graduate degree

Specify highest degree attained:

- ❑ M.D. / D.O.
- ❑ Ph.D. / Psy.D. / Ed.D.
- ❑ Pharm.D.
- ❑ M.A. or M.S.
- ❑ B.A. or B.S.
- ❑ B.S.N
- ❑ Other: _____

Are you currently employed? ❑ Yes ❑ No If No, when were you last employed? _____

Current occupation or last work if now unemployed: _____

Were you ever in the armed services? ❑ Yes ❑ No

Years of service (from when to when)? _____ Highest rank achieved: _____

Consent to Release Confidential Information to Another (Third) Party

I, _____ (print your name), am completing this form to allow the use and sharing of my protected health information with the staff clinical psychiatrist or any other entity as seen fit by Blossom Bariatrics and Blossom Medical Group in an effort to be psychologically evaluated and cleared for surgical treatment.

I understand and agree in the release of the final psychological evaluation with the my medical insurance as they deem necessary in efforts to obtain authorization for surgical treatment.

I understand and agree that this Authorization will be valid for one year from this date unless specified otherwise. I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization.

I understand that I do not have to sign this authorization, however, ***my refusal to sign will affect my abilities to obtain psychological clearance for surgical weight loss treatment from the Blossom Bariatrics and Blossom Medical Group thus resulting in denial of such treatment.***

I understand and agree that there may be administrative charges associated with the final review of the psychologic evaluation as provided by a professional which have been explained to me.

I affirm that I have been given the opportunity to ask any questions as they pertain to everything in this form that was not clear to me and I believe I understand it's contents.

Signature: _____ Date: _____