

# Nancy's Prevention Clinic

## Bariatric Psychiatric Evaluation

<b>Name:</b>		<b>Medication Allergies:</b>	<b>Date:</b>
DOB:	Age:	Primary Care Doctor:	/ Surgeon:
<b>Weight:</b>	<b>Height</b>	<b>BMI</b>	<b>LMP</b> <b>BC</b> <b>BP</b> / <b>p</b>
<b>Presenting Complaint:</b> <input type="checkbox"/> Anxiety <input type="checkbox"/> Hearing Voices <input type="checkbox"/> Mood Swings <input type="checkbox"/> Depression <input type="checkbox"/> Paranoia <input type="checkbox"/> Drugs <input type="checkbox"/> Other _____			
<b>How long have you had this problem?</b> <input type="checkbox"/> Within this last month <input type="checkbox"/> Less than 6 months <input type="checkbox"/> Greater than a year			

**Current Medical Conditions: (check all that apply)**

- |                                      |  |  |                                      |                                 |   |
|--------------------------------------|--|--|--------------------------------------|---------------------------------|---|
| <input type="checkbox"/> Allergies   | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Problem | <input type="checkbox"/> Head Injury | <input type="checkbox"/> HIV    | <input type="checkbox"/> Congestive Heart Failure |
| <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Cancer          | <input type="checkbox"/> Stroke      | <input type="checkbox"/> Asthma | <input type="checkbox"/> Lung problem             |
| <input type="checkbox"/> Other _____ |  |  |                                      |                                 |   |

**Symptoms: Please comment briefly**

- Sleep \_\_\_\_\_
- Appetite \_\_\_\_\_
- Depression/sadness/Crying spells \_\_\_\_\_
- Enjoyment \_\_\_\_\_
- Concentration (Can you pay attention?) \_\_\_\_\_
- Self Esteem/Confidence Level \_\_\_\_\_
- Anxiety/Agitation/moodiness \_\_\_\_\_
- Fatigue (Tired) \_\_\_\_\_
- Obsessions (Thoughts you can't quit thinking) \_\_\_\_\_
- Compulsive Behavior (Things you can't quit thinking or can't stop from doing) \_\_\_\_\_
- Spending Money \_\_\_\_\_
- Risk Taking \_\_\_\_\_
- Suicidal Thoughts (Thoughts, Plans, Actions) \_\_\_\_\_
- Paranoia (Fearful, People staring, someone wishing harm or poisoning you) \_\_\_\_\_
- Hallucination (Hearing voices, Seeing visions) \_\_\_\_\_
- Can you Stay Alone \_\_\_\_\_
- Have you ever Gamble \_\_\_\_\_
- Stressors \_\_\_\_\_

**List Psychiatric Medications used in past**

**Comment on how they worked**

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**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

<input type="checkbox"/> Nancy Bryant, FNP-C	Patient's Name
<input type="checkbox"/>	Date:

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## Bariatric Psychiatric Evaluation

***Patients Comments:***

1 Reason for the Evaluation  Approval for Bariatric Services  Other \_\_\_\_\_  
 Comment

2 Type of surgery  Gastric Banding  Roux-en-Y  Other \_\_\_\_\_  
 Comment:

3 How long will it help you?  One year  Several Years  Other \_\_\_\_\_  
 Comment:

4 How long has obesity been a problem?  Since childhood  Teen years  Postpartum  \_\_\_\_\_  
 Comment:

5 For how long did you stay on a diet - exercise program  1 month  3 months  6 months  \_\_\_\_\_  
 Comment:

6 Sources of stress presently  Work  Children  Spouse  Financial  \_\_\_\_\_  
 Comment:

7 Personal History  Mental Health Hospitalizations  Diagnosis \_\_\_\_\_  
 Comment:

8 Eating disorders present/past  Bulimia (overeating /purging)  Anorexia Nervosa  Overeating  
 Comment:

9 Marital Status  Married  Single  Other \_\_\_\_\_  
 Children  None  Toddlers  School age  Teens  Grown

***Comments: Add any other comments that you feel will help with your evaluation***

**Patient's Initials** \_\_\_\_\_ **Date:** \_\_\_\_\_

2-7

<input type="checkbox"/> Nancy Bryant, FNP-C	Patient's Name
<input type="checkbox"/>	Date:

# Nancy's Prevention Clinic

## Bariatric Psychiatric Evaluation

**PRESENT MEDICATIONS:**

Name	Over the Counter

**IMMUNIZATION HISTORY**

Immunizations Current: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
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**YOUR PSYCHIATRIC HISTORY**

- |   |  |
|---|--|
| <input type="checkbox"/> Alcoholism<br><input type="checkbox"/> Depression<br><input type="checkbox"/> Bipolar/ Manic Depression<br><input type="checkbox"/> Anxiety Disorders<br><input type="checkbox"/> Panic Disorders<br><input type="checkbox"/> Drug Abuse<br><input type="checkbox"/> Phobias<br><input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Obsessive-Compulsive Disorder<br><input type="checkbox"/> Suicide Attempt<br><input type="checkbox"/> Imprisonment<br><input type="checkbox"/> Post-traumatic Stress Disorder<br><input type="checkbox"/> Mental Retardation<br><input type="checkbox"/> ADD/HD<br><input type="checkbox"/> Eating Disorders<br><input type="checkbox"/> Other: |
|---|--|

**FAMILY PSYCHIATRIC HISTORY (Do not complete if you adopted)**

**Blood relative has had**

- |   |  |
|---|--|
| <input type="checkbox"/> Alcoholism<br><input type="checkbox"/> Depression<br><input type="checkbox"/> Bipolar/ Manic Depression<br><input type="checkbox"/> Anxiety Disorders<br><input type="checkbox"/> Panic Disorders<br><input type="checkbox"/> Drug Abuse<br><input type="checkbox"/> Phobias<br><input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Obsessive-Compulsive Disorder<br><input type="checkbox"/> Suicide Attempt<br><input type="checkbox"/> Imprisonment<br><input type="checkbox"/> Post-traumatic Stress Disorder<br><input type="checkbox"/> Mental Retardation<br><input type="checkbox"/> ADD/HD<br><input type="checkbox"/> Giftedness<br><input type="checkbox"/> Other: |
|---|--|

**YOUR MEDICAL HISTORY**

Allergies to food, environment, medications	
Hospitalizations	
Surgeries	
Injuries/Accidents	
Significant Illnesses	

**HAVE YOU EVER HAD:**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Headaches                  | <input type="checkbox"/> Weight Problems          | <input type="checkbox"/> Chickenpox       | <input type="checkbox"/> Anemia         |
| <input type="checkbox"/> Palpitation/ Skipped beats | <input type="checkbox"/> Constipation or Diarrhea | <input type="checkbox"/> Mumps            | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Dizziness/ Fainting        | <input type="checkbox"/> Menstrual Problems       | <input type="checkbox"/> Measles          | <input type="checkbox"/> Ear Infections |
| <input type="checkbox"/> Chest Pain                 | <input type="checkbox"/> Pneumonia                | <input type="checkbox"/> TB               | <input type="checkbox"/> Hay Fever      |
| <input type="checkbox"/> Shortness Of Breath        | <input type="checkbox"/> Urinating problems       | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Eczema         |
| <input type="checkbox"/> Stomach Problems           | <input type="checkbox"/> Hot or cold intolerance  | <input type="checkbox"/> Vision Problems  | <input type="checkbox"/> Heart Murmur   |

**Patient's Initials** \_\_\_\_\_ **Date:** \_\_\_\_\_

<input type="checkbox"/> Nancy Bryant, FNP-C	Patient's Name
<input type="checkbox"/>	Date:

# Nancy's Prevention Clinic

## Bariatric Psychiatric Evaluation

**FAMILY MEDICAL HISTORY (Do not complete if you adopted)**

**Blood relative has had**

- |  |   |
|--|---|
| <input type="checkbox"/> Thyroid Problems<br><input type="checkbox"/> Deafness<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Birth Defects<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Eczema | <input type="checkbox"/> Stroke<br><input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> Hay Fever<br><input type="checkbox"/> Cancer<br><input type="checkbox"/> Kidney Disease<br><input type="checkbox"/> Heart Disease<br>Other: |
|--|---|

**SUBSTANCE ABUSE HISTORY**

**LEGAL HISTORY**

- |                           |                              |                             |   |                                |                             |
|---------------------------|------------------------------|-----------------------------|---|--------------------------------|-----------------------------|
| Exposure To Tobacco Smoke | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Legal Problems                          | <input type="checkbox"/> Yes   | <input type="checkbox"/> No |
| Drug Use                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Recent Incarceration                    | <input type="checkbox"/> Yes   | <input type="checkbox"/> No |
| Alcohol Use               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Driving Under Influence                 | <input type="checkbox"/> Yes   | <input type="checkbox"/> No |
| Tobacco Use               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Workman's Comp | <input type="checkbox"/> Other |                             |
| Coffee/Soda Use           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |   |                                |                             |

**ACADEMIC HISTORY**

Highest Education Level:	<input type="checkbox"/> Graduate School <input type="checkbox"/> College Graduate <input type="checkbox"/> Partial College <input type="checkbox"/> High School Grad
	<input type="checkbox"/> Partial High School <input type="checkbox"/> Junior High School <input type="checkbox"/> Less than 7 years of school
	<input type="checkbox"/> Trade School <span style="float: right;">What area:</span>
	What year did you graduate? <span style="float: right;">What is your degree in?</span>

**PSYCHOTHERAPY HISTORY**

Have you been in psychotherapy in the past 6 months? <input type="checkbox"/> yes <input type="checkbox"/> No	With whom :
Start Date:	Stop Date :
What Type of Psychotherapy? <input type="checkbox"/> Cognitive <input type="checkbox"/> Behavioral	<input type="checkbox"/> Group <input type="checkbox"/> Supportive <input type="checkbox"/> Other

**ABUSE HISTORY**

Have you been sexually abused or molested? <input type="checkbox"/> Yes <input type="checkbox"/> No	By whom:
How old when it started?      How old when it ended?	
Corporal abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No    Emotional Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No	By whom:

**Patient's Initials** \_\_\_\_\_ **Date:** \_\_\_\_\_

<input type="checkbox"/> Nancy Bryant, FNP-C	Patient's Name
<input type="checkbox"/>	Date: