THE BOSTON INTERVIEW FOR BARIATRIC SURGERY

Patient's Name: _____ Date of Interview:
Date of Birth:
Clinician's Name: _____ Patient's Age:

DEMOGRAPHIC, EDUCATIONAL, EMPLOYMENT, FINANCIAL, FAMILY INFORMATION

The patient will have been asked to fill out a questionnaire containing this information, and bring it to the interview. Take a moment before the interview to skim the questionnaire, and ask more about information that is incomplete or seems to require further clarification or elaboration

Introduction: ***We're going to spend the next hour or so talking about a number of issues that pertain to your weight and your desire to have weight loss surgery. It is important for the positive outcome of any medical treatment you receive that you try to be as truthful and accurate as you can. If you don't understand a question, please ask me to explain it. If you prefer not to answer a question, you are free to skip it, but we prefer that you answer as many of the questions as you can.***

1. WEIGHT/DIET/NUTRITION HISTORY

I'm going to ask you some questions now about your weight and dieting history.

How tall are you? _____

How much do you weigh? _____

[BMI = weight (lbs) X 703] _____
height (in)^2

How has your weight been affecting you lately?

Weight History:

When did you first have a problem with your weight? (e.g., childhood, adolescence, pregnancy, menopause, etc.):

What has been the typical pattern since then? Has it been up and down frequently? What have the typical triggers been for gaining/losing weight?

Brief overview of weight fluctuations throughout patient's life; focus on precipitants/triggers/etiological factors:

What is the lowest (adult) weight you ever attained (through deliberate effort)?

(Weight attained) _____

For how long did you maintain this weight? _____

(If different from above),

how long do you typically maintain a major weight loss? _____

What is the highest your weight has ever been, and when was this?

Weight _____ Date/age _____

Current and Past Weight Loss Attempts

Are you doing anything currently to control your weight?

(If yes) ***What are you doing?***

Has it worked well?

How easy or difficult have you found it to be? What do you like/dislike about it?

When you have tried to lose weight in the past, has anything worked well? How long did it take, and how long did you keep it off? What was it that made that method helpful? What factors led to weight regain?

(For each method that has worked well, record the approximate date, how much weight loss was achieved, how long it took to achieve weight loss, how long weight loss was maintained, what led to regain, and what factors made this method successful/what they liked or disliked about it.)

Year	Method	Amount Lost	Time to achieve	Time maintained	Regain trigger(s)	Helpful factors

Is there anything you have tried in the past to lose weight that did not work well? Why do you think it was not effective?

(For each method that has not worked well, record the approximate date, how long it was tried, what the result was (e.g., lost only 5# and "gave up"), and the patient's theories about why this method did not work

Year	Method	Result	Duration	Why not effective

Daily Intake

Note: The patient will have been sent a self-monitoring sheet and asked to list all foods eaten during a typical day. Please briefly examine this sheet and ask about anything that requires clarification or elaboration.

Food Preferences and Sources

Do you have a certain type of food(s) that you consider your "weakness(es)"?

How often do you drink high-calorie beverages like soda, juice, sports drinks, of other sweet drinks?

Who shops for and prepares most of your food?

Where do you get meals when you are at school/work?

How often do you eat at restaurants? _____ times per week

How often do you eat take-out? _____ times per week

How often do you eat fast food? _____ times per week

Portion Sizes

Are your portion sizes typically small, medium, or large? Can you give examples?

Are there specific times/situations when you are more likely to eat larger portions?

Eating patterns

Do you have a regular eating pattern?	(Y/N?)
What is it?	
How many meals or snacks do you eat in a typical day?	
What is the timing of your meals and snacks?	
Do you frequently go more than 3-4 hours without eating anything?	(Y/N?)
(If yes) ***Does this lead to eating more the next time you eat?***	(Y/N?)
Do you tend to eat when you are bored?	(Y/N?)

2. EATING PATHOLOGY

Now I'm going to ask you about a few different types of eating behaviors.

Bingeing and Purging

Note: Interviewer should familiarize him/herself with binge and purge criteria before interview. Note that episodes of bingeing in and of themselves do not constitute Binge Eating Disorder. Because bingeing and purging are important to assess, these questions may also be assessed with the self-report QEWP-R questionnaire or EDE-Q. If such a questionnaire is used, take a moment to look over the patient's responses on the QEWP-R before you begin this section of the interview. Then ask the bold-faced, bulleted questions as necessary.

Binge Eating	Current	Past
Have you ever had a time when you've eaten a very large amount of food in a short space of time (say, under two hours) - a lot more food than most people would eat in a similar situation?	(Y/N?)	(Y/N?)
Did you feel out of control while you were eating this way? Did you feel you could not stop?	(Y/N?)	(Y/N?)
Example ***(Can you give me an example of what you'd eat in a typical episode/what did you eat the last time this happened?) – specify amount(s)***		

Meets criteria for binge episode?	**Yes**	**No**	**Frequency** (e.g., 2x/wk)	**Duration** (e.g., 6 months)
Current				
Past (Specify when)				

Features of binge episodes	Current	Past
Eats more rapidly than is normal		
Eats beyond satiety		
Eats when not hungry		
Eats alone because embarrassed/ashamed		
Feels disgusted or depressed after overeating		

Diagnostic criteria	Current	Past
Experiences marked distress around binge episodes?		
MEETS CRITERIA FOR BED? **(Full binge episodes at least 2x/wk for at least 6 months; at least 3 associated features; marked distress around binge episodes)**		

Do you or have you ever tried to control your weight by "getting rid of" what you'd eaten in any of the following ways?

Purging	Current	Past (Specify when)	Frequency (e.g., 2x/wk)	Duration (e.g., 6 months)
Self-induced vomiting				
Laxatives (2+ times normal dose)				
Diuretics (2+ times normal dose)				
Diet pills (2+ times normal dose)				
Excessive exercise				
Other (Specify:)				

Grazing

Do you tend to eat set meals and snacks, or do you find that you have times when you will eat continuously during the day or the evening?

___ Yes ____ No

(If yes) ***When is this most likely to happen?***

Emotional Eating	
Do you find that you frequently (> 2x/wk) eat in response to negative emotions?	
Do you find that you frequently (> 2x/wk) use food as a coping mechanism?	
Do you find that you frequently (> 2x/wk) use food to calm or "medicate" yourself?	
Are your current emotions or stressors contributing to your weight by causing you to eat more?	
Do you feel that eating in response to emotions contributes significantly to your weight or makes it difficult to lose weight?	
Emotional Eating (endorses any of the symptoms above)**?**	

Night Eating	
1. Do you ever wake up in the middle of the night?	(Y/N)
1a. When you wake up in the middle of the night, how often do you eat at that time?	(≥ 3 times/week? Y/N)
2. Do you think that at least a quarter of your day's calories are eaten after dinner?	(use food record to evaluate, if possible) (Y/N) If no to both 1a and 2, stop here
3. Do you find that you are not hungry when you wake up in the morning?	(Y/N)
4. Are you very distressed by this pattern of eating?	(Y/N)

Patient Attributions Regarding Weight

What do you think are the main contributors to your weight? (e.g., genetics, poor food choices, large portions, meal/snack patterns, emotional eating, time constraints, lack of exercise, smoking cessation, medications, menopause, other medical conditions, etc.)

MEDICAL HISTORY

Review medical information section from Patient Information Form

Interviewer: Make special note of how well patient understands why he is on each of his meds and what they are for. Assess whether s/he is the person who is responsible for own meds or if someone else takes primary responsibility for this. Assess patient's history of adherence to medical treatment/recommendations (Examples – frequency of blood glucose monitoring; consistency of CPAP use; adherence to medication regimen; adherence to diabetic diet)

Notes on medical history and responsibility for/knowledge of medication, and history of adherence:

4. KNOWLEDGE OF PROCEDURES, RISKS, AND POST-SURGICAL REGIMEN

Now I am going to ask you about what you know about the surgical procedure, the risks involved with it, and the changes you would have to make in your diet after you had the surgery.

> Note to interviewer: After asking about each risk/side effect, briefly educate the client about each aspect, where necessary.

The Surgical Procedures

Can you describe what happens during bariatric surgery? Does patient understand the operation itself? 1 = Poor, 2 = Fair, 3 = Good, 4 = Very Good, 5 = Excellent, 0 = Did not assess	
Gastric Bypass • Very small pouch created with staples • Intestine is connected to pouch • Portion of intestine is "bypassed"	
Gastric Banding • Very small pouch created with inflatable silicone ring • Ring is stitched into place • Ring is filled with saline in order to narrow the opening to the rest of the stomach and cause rapid satiety and delayed hunger • Regular (nonsurgical) adjustments are required to maintain optimal fill level	

Risks and Side Effects

What do you know about the risks and side effects associated with bariatric surgery? Place a check beside each risk/side effect of which the patient is aware, give global rating based on these responses.	
Gastric bypass	
Death *(mortality rate w/in first 30 days currently estimated at 0.5%)*	
Blood clots	
Wound infections	
Ulcers	
Hernias	
Leakage from pouch/staple line breakdown	
Dehydration	
Dumping syndrome *(nausea, light-headedness, flushing and diarrhea)*	
Vomiting	
Lactose intolerance	
Nutritional deficiencies	
Excess skin	
Hair loss *(temporary and can be minimized with adequate protein intake)*	
Gastric banding	
Death *(mortality rate w/in first 30 days currently estimated at .05%)*	
Blood clots	
Wound infections	
Vomiting	
Dehydration	
Excess skin	
Hair loss *(temporary and can be minimized with adequate protein intake)*	
Global rating of the patient's knowledge of risks and side effects of the procedure 1 = Poor, 2 = Fair, 3 = Good, 4 = Very Good, 5 = Excellent, 0 = Did not assess	

Post-Surgical Behavioral Regimen

Tell me about the ways in which your diet will change after the surgery. **Note** This information will vary depending on where the patient is having surgery. For each box, give a global rating of the patient's knowledge about post-surgical dietary restrictions, based on his or her knowledge of the bulleted points below. 1 = Poor, 2 = Fair, 3 = Good, 4 = Very Good, 5 = Excellent	
What will your diet be like for the first few weeks? • Meal portions must be limited to 2 ounces or 4 tablespoons • This may increase, but will probably never be larger than a child-sized portion. • Low sugar, low fat, liquid/soft diet	
Which foods must you avoid or limit? • Soft, fatty foods *(e.g., ice cream, chocolate, cheese, cookies, easily crumbled junk food like chips)* • High calorie liquids *(e.g., sports drinks, milkshakes, juices)* • Sweets *(can cause dumping syndrome)* • Obstructive foods *(tough, fatty red meat, breads made with refined flour, wide types of noodles, membranes of citrus fruits)* • Carbonated beverages *(strong anecdotal evidence linking carbonated beverages to weight regain)* • Alcohol *(first 6-12 months – dehydrating; will affect patient more quickly and strongly after surgery)* • Caffeine *(first several months – diuretic)*	
What would your optimal habits be after the initial recovery period? • 4-6 small meals a day – eat every 3-4 hours • Eat very slowly - chew carefully and completely • Be sure to stop eating when you feel satisfied, not full • Very small portions • Do not drink beverages with meals or within 30 minutes of eating. *(causes food to move through the stomach too quickly; can lead to excess hunger)* • Do not diet; work on achieving a healthy balance; no foods (exceptions above) are "off-limits" • Engage in daily physical activity	

5. MOTIVATION AND OUTCOME EXPECTATIONS

Motivation

I'm going to list a few reasons why some people want to have weight loss surgery. On a scale of 1-5, how important is each one to your desire to have this surgery? Which one is the most important reason?

1 = Not At All 2 = Slightly 3 = Moderately

4 = Considerably 5 = Extremely N/A = Not Applicable

Circle the most important reason

Increased mobility	_____
Increased energy	_____
Resume/adopt new activities	_____
Improved social life	_____
Enhanced occupational functioning	_____
Improved health	_____
Prevent future health problems	_____
Increased longevity	_____
Decreased pain	_____
Feel better	_____
Improved appearance	_____
Improved self-esteem	_____
Improved sex life	_____
Improved relationship with partner or spouse	_____
Practical reasons (fit into airplane seat, tie shoes, clothes shopping, etc.)	_____
Other (describe_____)	_____

Comments:

Outcome Expectations

Rate patient's knowledge about post-surgical outcome:

1 = Poor, 2 = Fair, 3 = Good, 4 = Very Good, 5 = Excellent, 0 = Did not assess

How much weight do you expect to lose after the surgery? • Ideally patient will lose 60-70% of excess body weight. *Note: you may want to use a BMI chart, with BMI = 25 as the "normal" weight baseline to determine whether expectations are realistic.* • People who eat healthfully and are consistently active tend to lose more • Younger people tend to lose more than older people	
How long will it take for maximum weight loss? • Most rapid during the first few months after surgery. • Maximum weight loss can take up to two years	
What is the typical pattern of weight regain? • Average: 10-15% of what was lost by 5 yr follow-up • Can be more if unhealthy behaviors continue or recur, including a chance of regaining almost all of the weight lost.	
Were you aware that "old" behavior patterns often recur? • Fairly common; tends to occur between 18 and 24 months post-op but can be even longer	
Were you aware that some people develop problematic behavior patterns long after surgery? • Fairly uncommon, but has been noted • Alcohol/drugs, shopping, gambling, sex	

Adherence

How will it be for you to change your eating patterns? Do you worry that you will have feelings of loss or deprivation?

If you have coped with emotions in the past by eating, what other coping strategies will you use if you have the surgery?

Will you be able to obtain and prepare the foods you need? What might get in the way?

How will your living environment affect your attempts to eat healthfully?

Will your daily schedule of work or other responsibilities allow you to eat frequently and healthfully, and engage in frequent physical activity?

6. RELATIONSHIPS/SUPPORT SYSTEM

How do your friends and family feel about your desire to have bariatric surgery?

Who will be available to help care for you immediately after surgery?

If you are successful in losing weight, how might this affect your relationships?
(spouse or partner, family, friends, co-workers, others)

Is there anyone who might feel unhappy or uncomfortable with your weight loss?

If necessary, would this person (people) be willing to come in for a consultation before your surgery?

7. PSYCHIATRIC FUNCTIONING

Note: Interviewer should have basic skills in taking a psychiatric history and conducting a mental status exam; therefore, questions in this section are not scripted.

Axis I Screening

	Current:		Past	
Sx of major depression	___ Yes	____ No	___ Yes	____ No
Sx's of mania/hypomania	___ Yes	____ No	___ Yes	____ No
Suicidality	___ Yes	____ No	___ Yes	____ No
(specify/describe)				
GAD	___ Yes	____ No	___ Yes	____ No
Panic attacks	___ Yes	____ No	___ Yes	____ No
Other significant anxiety Sxs	___ Yes	____ No	___ Yes	____ No
(specify/describe)				
Psychotic Sx's	___ Yes	____ No	___ Yes	____ No
(specify/describe)				

Trauma History

Physical/Sexual abuse ___ Yes ____ No

(specify/describe)

Other trauma history

(specify/describe)

If trauma or abuse Hx:

Active Sx's of PTSD? ___ Current ___ Past ____ None

Current and Past Mental Health Treatment

Psychotropic Medications

Current Psychotropic meds

(specify type/indication/who prescribes)

Past psychotropic meds

(specify type/indication)

Psychiatric Hospitalization(s)

Dates/ Diagnoses/Presenting problem(s)

Outpatient Psychotherapy Current _____ Past _____

Dates/ Diagnoses/Presenting problem(s)

Name of current/recent provider(s) Contact information

Release obtained?

Substance Abuse/Dependence

Review Substance Abuse information from Patient Information Form

- Alcohol

  What is your current use of alcohol?

  (If no current problem drinking): **Has there ever been a time in the past when you were drinking more at a time, or more frequently?**

  (If applicable): **Has (current/past) use of alcohol ever created any problems for you?**

  (If yes, assess with regard to DSM criteria for abuse/dependence)

  Alcohol abuse Current _____ Past _____
  Alcohol dependence Current _____ Past _____

  Outcome (treatment Hx and years of sobriety, if applicable):

- Drugs

  What is your current use of drugs?
  (If present, assess with regard to DSM criteria for abuse/dependence)

  Have you ever used any drug regularly in the past?
  (If yes, assess with regard to DSM criteria for abuse/dependence)

  Drug abuse Current _____ Past _____
  - Specify substance(s):

  Drug dependence Current _____ Past _____
  - Specify substance(s):

  Outcome (treatment Hx and years of sobriety, if applicable):

- Smoking

  Do you currently smoke cigarettes?

  (If yes): **How long have you been smoking?**

  (If yes): **How many cigarettes do you smoke on a typical day?**

  (If yes): **How would it be for you to stop smoking if your surgeon required it?**

Family History of Psychiatric Problems

(Specify relative/type of problem)

Family History of Substance Abuse

(Specify relative/type of substance)

Mental Status Exam

Please answer the following in terms of current functioning: (Yes/No)

1. Alert _____
2. Oriented _____
3. Groomed _____
4. Cooperative _____
5. Memory Impairment _____
6. Concentration Impairment _____
7. Judgment Impairment _____
8. Suicidal Ideation _____ (active/passive; with/without plan)
9. Homicidal Ideation _____ (active/passive; with/without plan)
10. Speech _____ (pressured, slowed, other)
11. Psychomotor _____ (agitation, retardation)

Notes on General Functioning, Severity/Degree of Impairment: