



The Bariatric & Metabolic
WEIGHT LOSS CENTER
A Subsidiary of Piedmont Family Practice

Binge Eating Disorder Questionnaire

Name: _____ DOB: _____ Date: _____

The Following questions ask about your eating patterns and behaviors within the last 3 months. For Each question, choose the answer that best applies to you.

- 1.) **During the last 3 months**, did you have any episodes of excessive overeating (i.e. eating significantly more than what most people would eat in a similar period of time)?
 - Yes
 - No

- 2.) Do you feel distressed about your episodes of excessive overeating?
 - Yes
 - No

Within the past 3 months:	Never OR Rarely	Sometim es	Often	Always
During your episodes of excessive overeating , How often did you feel you had no control over your eating (ex: Not being able to stop eating, feeling compelled to eat, or going back and forth for more food)?	•	•	•	•
During your episodes of excessive overeating , How often did you continue eating even though you were not hungry?	•	•	•	•
During your episodes of excessive overeating , How often were you embarrassed by how much you ate?	•	•	•	•
During your episodes of excessive overeating , How often did you feel disgusted with yourself or guilty afterward?	•	•	•	•
During the last 3 months , How often did you make yourself vomit as a means to control your weight or shape?	•	•	•	•