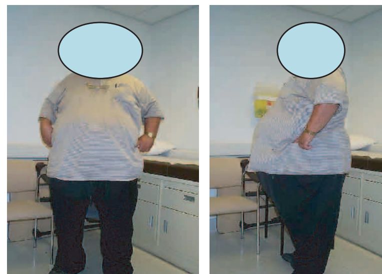
Dear Patient:

WeightLossSurgery Inc. is responsible for collecting all the necessary information that will be used by the bariatric surgeon during the consultation in the office to assess your suitability for weight loss surgery. Please complete the enclosed PATIENT INFORMATION PROFILE as accurately as you can.

Please pay particular attention to the PAST SURGICAL HISTORY section. It is important that you provide as much detail as possible about any type of previous surgery, especially any surgery on your stomach e.g. Nissen Fundoplication or "stomach wrap".

Along with this PATIENT INFORMATION PROFILE provide any additional medical history e.g. letters from your referring physician, copies of previous hospitalizations, operative reports, etc., if available. You must also write a short letter describing your previous attempts to lose weight and why you think that surgery is the only option.

You must also provide some recent photographs of yourself. The ideal pose is a full frontal pose and a side pose standing up, as shown below.



Patients from outside Quebec and those Quebec patients with BMI<55 considering alternate options outside the public system must provide a data processing fee of $150.00 (check made out to"Weightlosssurgery Inc."). Quebec patients with BMI>55 must provide a consultation from another physician.

Please be sure to sign the information release form giving WeightLossSurgery inc. permission to give your completed history to the bariatric surgeon.

After we receive this information we will ensure that it is duly completed. If there is information missing we will call you for clarification. When we are satisfied that all information is complete we will start an electronic record. You will then be contacted for an appointment with Dr. Christou.

Complete the check list and mail the completed package via regular mail (do not register or courier) to the address below.

Mail the completed Package to:

Weightlosssurgery Inc
c/o Bariatric Team
687 Pine Ave. West
Montreal, Quebec H3A 1A1

Check List:

- [ ] Patient Questionnaire Complete
- [ ] Pictures
- [ ] Operative Reports, etc.
- [ ] Check for C$150.00

Print Form

Weight Loss Surgery Inc.
Phone: 514-843-1531
Fax: 514-843-1693
www.weightlosssurgery.ca

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WLS Weight Loss Surgery

Patient Questionnaire

Authorization For Release Of Information

I

hereby authorize WeightLossSurgery Inc. to disclose my individually identifiable health information to the bariatric surgeons and staff of the McGill University Health Center, the Centre Metropolitain du Chirurgie Plastique, or the Montreal Comprehensive Weight Management Program. This information will be used to assess my candidacy for bariatric surgery and allow the team to provide all pre-operative, operative and post-operative care. I understand that both WeightLossSurgery Inc. and the bariatric surgeons and staff of the above centers agree to abide by the NOTICE OF PRIVACY PRACTICES, which is available for inspection at any time.

Signed:

Date:

Witness:

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WLS Weight Loss Surgery

Patient Questionnaire

Personal Details

Surname: Given Names:

Address 1:

Address 2: Postcode:

Telephone No: (Home) (Business):

Mobile No:

e-mail:

Date Of Birth: Age:

Occupation:

Medicare Card Number:

Weight: (lbs or kg) Height: (inches or centimetres) BMI:

Other Contact Information:

This information is often vital to us if we need to contact you urgently. Occasionally people move orhave new phone numbers and do not let us know.

1. NEXT OF KIN

Name: Relationship:

Address:

Telephone No: (Home) (Business):

2. ADDITIONAL CONTACT

Name: Relationship:

Address:

Telephone No: (Home) (Business):

3. ADDITIONAL CONTACT:

Name: Relationship:

Address:

Telephone No: (Home) (Business):

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WLS Weight Loss Surgery

Patient Questionnaire

Referral Information

Referring Doctor: Date of referral:

Address:

Telephone Contact:

Local Doctor:

Address:

Telephone Contact:

Specialist Physician (pulmonologist, gastroenterologist, endocrinologist):

Address:

Telephone Contact:

Social Profile

Family Structure:

Married: Single:

Divorced: Partner/Relationship:

Children/Ages:

Support persons/friends:

Do you have a pet? If so, give details:

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Patient Questionnaire

Weight History

Please indicate whether you consider your weight was below average, average, above average or very heavy inthe relevant boxes at the following times

	Below Average	Average Weight	Above Average	Very Heavy
Birth Weight				
Weight at starting school (5-6 years)				
Weight at beginning of high school (10-12 yrs)				
Weight at end of high school (15-18 years)				
Weight at time of commencing work (21 years)				
Weight at time of marriage (if applicable)				

Weight Loss History

Past Attempts At Weight Loss

Non-Supervised Attempts (check all that apply)

Body for Life / Bill Phillips		Pritikin	
Gloria Marshall Richard		Simmons	
Health Spa		Scarsdale	
High Protein		Stillman Diet	
Hypnosis		Sugar Busters	
Low Carbohydrate		Slim Fast	
Low Fat		Mayo Clinic	
Calorie Counting on my own		Other	

Give additional details if any:

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Patient Questionnaire

Weight Loss History

Past Attempts At Weight Loss

Supervised Diet Attempts (check all that apply)

Diet Pills from MD	☐	Diet Shots from MD	☐
Diet Center	☐	Overeaters Anonymous	☐
Optifast	☐	Weight Watchers	☐
HMR – Health Management Resources	☐	Nutri-Systems	☐
T.O.P.S.	☐	Jenny Craig	☐
New Direction	☐	National Weight Loss	☐
Supervised calorie counting diet by health professionals	☐	Other?	☐

Details of any other weight loss measures (including surgical):

Was there any particular event that lead to significant weight gain:

Medication Prescribed For Weight Loss (Medications may be listed as both as generic and namebrand. Check the one prescribed to you)

Acutrim	☐	Obalan	☐	Adipex-P	☐
Orlistat Amphetamines	☐	Phendiet	☐	Anorex	☐
Phentermine	☐	Benzphetamine	☐	Phentrol	☐
Dexatrim	☐	Plegine	☐	Dexfenfluramine	☐
Pondimin	☐	Didrex	☐	Redux	☐
Fastin	☐	Sanorex	☐	Fenfluramine	☐
Tepanol	☐	Ionamin	☐	Tenuate	☐
Mazanor	☐	Wehless	☐	Meridia	☐
Xenical	☐				

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WLS Weight Loss Surgery

Patient Questionnaire

Family Medical History

Do you have a family history of any of the following and if so, please indicate:

	PARENT	SIBLING / CHILD	OTHER RELATIVES (cousins, aunts, grandparents etc)	NO FAMILY HISTORY	DON'T KNOW
Diabetes					
Heart Disease					
Hypertension					
Gout					
Gallstones					
OBESITY					
Snoring / sleep apnoea					
Asthma					
Allergies					
Hayfever					
Dermatitis / Eczema					
High Cholesterol					
Osteoporosis					
Hip fractures					

ALLERGIES (including foods, medications, dressings): Yes ☐ No ☐

If yes, please give details:

ALCOHOL: Do you drink alcohol: Never ☐ Regularly ☐

Do you drink: Wine ☐

How many standard glasses do you drink per day ☐ How many days do you drink per week ☐

SMOKING: Do you smoke? Yes ☐ No ☐ Never ☐ If yes: how many per day? ☐

Have you smoked in the past? Yes ☐ No ☐ If so, how many per day? ☐

For how many years ☐ When did you stop smoking? ☐

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WLS Weight Loss Surgery

Patient Questionnaire

Family Medical History

FOR WOMEN ONLY:

Do you have regular periods (26 - 33 days)? Yes ☐ No ☐
If not, please describe

Do have problems with excessively heavy periods? Yes ☐ No ☐
If Yes, please described

Have you had difficulty in conceiving in the past? Yes ☐ No ☐

Do you currently have problems with infertility? Yes ☐ No ☐

Have you suffered from excess body hair or acne? Yes ☐ No ☐

Have you every been told by a doctor that you have polycystic ovaries? Yes ☐ No ☐

Have you had problems with pregnancy and/or childbirth? Yes ☐ No ☐
If so, in what way?

Have you had a caesarean section? Yes ☐ No ☐
If so, why?

Employment

Current Employment:

Are you currently employed?

Are you full-time, part-time or casual?

If you are unemployed, what is the reason?

Are you actively looking for work?

Has your weight made it difficult to find employment?

If employed, please state what level of activity your job involves

Little (sedentary job) ☐ Moderately active ☐ Very active (Labouring, etc.) ☐

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WLS Weight Loss Surgery

Patient Questionnaire

Sleep History

How many hours sleep do you get a night? [ ]

Is there any thing else that keeps you awake at night? Yes [ ] No [ ]

Details:

Would you consider the quality of your sleep is Good [ ] Fair [ ] Poor [ ]

If your sleep is a major problem to you or your partner, would you be prepared to have a sleep study performed now and after you lose weight? Yes [ ] No [ ]

SYMPTOMS OF SLEEP APNOEA

To answer each question, mark the horizontal line with an X in the position that best indicates youranswer.

Question				
1. How often do you snore?	NEVER		ALWAYS	
2. Do you wake during the night with a choking feeling?	NEVER		ALWAYS	
3. How often would you sleep more than 8 hours in total in a 24 hour period?	NEVER		ALWAYS	
4. How often do you wake up more than once during the night?	NEVER		ALWAYS	
5. Do you have a headache when you wake up in the morning?	NEVER		ALWAYS	
6. Have you noticed a reduction in your libido or sex drive?	NEVER		ALWAYS	
7. Do you feel sleepy during the day?	NEVER		ALWAYS	
8. Has anyone noticed that you momentarily stop breathing during your sleep?	NEVER		ALWAYS	
9. Do you fall asleep while reading?	NEVER		ALWAYS	

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Patient Questionnaire

Sleep History

Question				
10. Do you wake up in the morning feeling confused?	NEVER		ALWAYS	
11. How often do you have a nap during the day?	NEVER		ALWAYS	
12. Do you feel sleepy in the evenings?	NEVER		ALWAYS	
13. Have you or anyone else noticed a change in your personality recently?	NEVER		ALWAYS	
14. How often do you doze off or fall asleep while driving?	NEVER		ALWAYS	

How likely are you to **doze off or fall asleep** in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently, try to work out how they would have affected you.

Use the following table to choose the **most appropriate option** for each situation by placing a tick in the boxes below:

Situation	Never doze	Slight chance of dozing	Moderate chance of dozing	High chance of dozing
Sitting and reading				
Watching TV				
Sitting, inactive in a public place (e.g. a theatre or a meeting)				
As a passenger in a car for an hour without a break				
Lying down to rest in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a lunch without alcohol				
In a car, while stopped for a few minutes				

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WLS Weight Loss Surgery

Patient Questionnaire

Review of Medical Problems (Please check and/or explain any of the items listed)

Cardiovascular

Heart problems ☐ ______

Chest pains ☐ ______

Racing heart/skipping ☐ ______

High blood pressure ☐ ______

Chest tightness ☐ ______

Shortness of Breath ☐ ______

SOB while exercising ☐ ______

High cholesterol ☐ ______

High triglycerides ☐ ______

Feel tired all the time ☐ ______

Diabetes And Endocrine System

Diabetes Mellitus ☐ **Yes** ☐ **No**

When was your diabetes first diagnosed? ______

How long have you been taking oral agents? ______

How long have you been taking Insulin? ______

Pre-diabetic (Abnormal glucose tolerance test)

Gestational ______

Age of diagnosis ______

Hypoglycemia ______

Thyroid Problems ☐ **Yes** ☐ **No** **Medication:** ______

Gastrointestinal

Gallbladder Problems ☐ **Yes** ☐ **No**

Do you have gallstones diagnosed by ultrasound? ______

Have you had your gallbladder removed? ☐ Yes ☐ No If YES ☐ open ☐ laparoscopically

Stomach Ulcers ☐ **Yes** ☐ **No**

Enter medicine taken for ulcers? ______

Heartburn ☐ **Yes** ☐ **No**

How often do you have heartburn and do you take medications for it? ______

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WLS Weight Loss Surgery

Patient Questionnaire

Review of Medical Problems (Please check and/or explain any of the items listed)

Respiratory

Asthma ☐ **Yes** ☐ **No** Last attack? ________

Bronchitis ☐ **Yes** ☐ **No** # Of times in past 2 yrs? ________

Is it recurring? ☐ Yes ☐ No

Pneumonia? ☐ Yes ☐ No

Blood clots in lungs? ☐ **Yes** ☐ **No**

Blood Clots in Legs? ☐ **Yes** ☐ **No**

Lung Reserve

Do you get short of breath easily?	☐ Yes	☐ No
Can you walk 1 city block without having to stop and catch your breath?	☐ Yes	☐ No
Can you climb a flight of stairs without stopping?	☐ Yes	☐ No

If you answered NO, why do you need to stop? ________

Musculoskeletal

	Mild	Moderate	Severe
Hip pain	☐	☐	☐
Knee pain	☐	☐	☐
Ankle pain	☐	☐	☐
Feet pain	☐	☐	☐
Back pain	☐	☐	☐
Neck pain	☐	☐	☐
Arthritis	☐	☐	☐

Are you using anti-inflammatory or pain medicine?	Yes ☐	No ☐
Do you have swelling of your legs?	Yes ☐	No ☐
Do you have swelling of your feet?	Yes ☐	No ☐
Do you have varicose veins?	Yes ☐	No ☐
Do you have ulcers of the leg?	Yes ☐	No ☐

Kidney & Bladder

Do you spill urine when coughing or laughing?	Yes ☐	No ☐
Have you had bladder or kidney infections?	Yes ☐	No ☐
Have you had kidney stones?	Yes ☐	No ☐

Blood

Have you ever had a bleeding problem?	Yes ☐	No ☐
Have you ever had low platelets?	Yes ☐	No ☐
Have you ever had a blood transfusion?	Yes ☐	No ☐

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WLS Weight Loss Surgery

Patient Questionnaire

Review of Medical Problems (Please check and/or explain any of the items listed)

Neuro-Psychiatric

Question	Yes	No
Do you suffer from Depression?	Yes	No
If YES do you think it is because of obesity?	Yes	No
Are you taking medication for depression?	Yes	No
Do you have Seizures?	Yes	No
Requiring medication?	Yes	No
Severe headaches?	Yes	No
Requiring medication?	Yes	No
Visual problems?	Yes	No
Been in counseling?	Yes	No
History of alcohol abuse?	Yes	No
How long have you been sober?	Yes	No
History of drug abuse?	Yes	No
How long have you been clean?	Yes	No
Do you suffer from Bulimia?	Yes	No
Do you suffer from Anorexia Nervosa?	Yes	No
Do you suffer from Other Eating disorder?	Yes	No

Past Surgical History

Check the type of surgery (if any) below:

Surgery	Check	DATE(s)
No previous surgery		
STOMACH (please give details below)		
NISSEN FUNDOPLICATION		
Cholecystectomy (gallbladder removal)		
Appendectomy		
Hysterectomy (removal of uterus)		
Cesarean Section (C-section)		
Oophorectomy (removal of ovary)		
Other		

Give additional details if any:

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Patient Questionnaire

Review of Medical Problems (Please check and/or explain any of the items listed)

MEDICATIONS: (Report name, dose and frequency and what you are taking it for)

Medication	Dosage	Frequency	For what condition?

How did you hear about us?

Other comments?

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