



PATIENT HEALTH HISTORY

Weight Management Clinic

Date (yyyy/mm/dd)	Age	Sex <input type="checkbox"/> F <input type="checkbox"/> M
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Referring care provider:

Last name	First name
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Father's first name	Mother's maiden name	Do you have medical insurance?
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Home Phone Number	Work Phone Number	Cell Phone Number
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Reason for referral: _____

Bariatric surgery consult

If you are considering surgery, are you able to budget for the Optifast product as a food replacement for 3 weeks prior to surgery (approximately \$300) and post-operative nutritional supplements (approximately \$60/month) for life following surgery? Yes No

Medical weight management consult

If you are considering the Core medical program, do you feel as though you are able to budget for the Optifast product as a food replacement which is approximately \$100/week or \$400/month? Yes No

Education:

<input type="checkbox"/> No High School	<input type="checkbox"/> Some High School
<input type="checkbox"/> High School diploma	<input type="checkbox"/> Completed post-secondary
<input type="checkbox"/> Graduate studies	<input type="checkbox"/> Other

Any special needs:

<input type="checkbox"/> Visual impairment	<input type="checkbox"/> Physical impairment
<input type="checkbox"/> Hearing impairment	<input type="checkbox"/> Learning disability

Other (please describe your needs and how we can accommodate you):

Languages spoken:

English French Other: _____

Are you able to understand group sessions delivered in English? Yes No

How would you identify yourself:

Aboriginal African Arabian Asian

Caucasian Latino Multiracial

Would rather not say Other: _____

Do you have any religious or spiritual practices that may affect your care?

Yes No

Please describe:

Employment status:

Student: Full-time Part-time

Employed:

Do you work shift work?

If yes, which shifts?

Yes No

Days Evenings Nights

Are you in danger of losing your job because of obesity?

Yes No

Unemployed:

Ontario Disability Support Plan

Ontario Works

Pension

Other: _____

I would describe my financial situation as:

Adequate to meet my needs

Inadequate to meet my needs

Social Support System:

Do you feel safe at home? Yes No

Is your partner/family supportive of your weight loss? Yes No

Do you have a supportive group of family and friends around you? Yes No

Health care usage: In the past 3 months, have you used any of the following health care services?

Family doctor visit(s) Yes – How many times: _____ No

Hospitalization(s) visit(s) Yes – How many times: _____ No

Emergency room visit(s) Yes – How many times: _____ No

Specialist visit(s) Yes – How many times: _____ No

Weight History

Height: _____ Current weight: _____ Goal weight: _____

As an adult what has been your highest weight : _____ and your lowest weight: _____

What years of age have you been overweight (check all that apply):

Less than 8 years of age 8-10 11-13 14-16

17-19 20-25 26-30 31-40 41-50

51-60 61-70 71-80 71 and over

Do you think your life will change after losing weight? Yes No

Please describe:

Eating Behaviours

Are there specific things that you connect your weight problem to (check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Specific life event | <input type="checkbox"/> Medical condition/illness | <input type="checkbox"/> Busy lifestyle |
| <input type="checkbox"/> Boredom eating | <input type="checkbox"/> Snacking/grazing | <input type="checkbox"/> Emotional/stress eating |
| <input type="checkbox"/> Poor understanding of healthy eating habits | <input type="checkbox"/> Lack of physical activity | |
| <input type="checkbox"/> Unsure | <input type="checkbox"/> Other: _____ | |

Do you ever skip meals? Yes No

Who cooks meals at home? _____

On average, how often do you consume fast food (e.g. McDonald's, Tim Horton's, Wendy's, Subway, etc.): Never

- | | |
|--|---|
| <input type="checkbox"/> Occasionally (fewer than 2 times per month) | <input type="checkbox"/> Once a week |
| <input type="checkbox"/> A couple of times per week | <input type="checkbox"/> Several times per week |

Who does the grocery shopping?

Have you ever made yourself vomit after eating? Yes No

Have you ever taken laxatives after eating? Yes No

Have you ever been referred to an Eating Disorders Clinic? Yes year: _____ No

Have you ever had a diagnosis of:

Anorexia nervosa? Yes year: _____ No

Bulimia? Yes year: _____ No

Do you have times when you binge eat (eat large volumes of food)? Yes No

Have you ever been diagnosed with Binge Eating Disorder? Yes year: _____ No

If you do binge eat, which of the following might cause you to binge (check all that apply):

- No particular reason Boredom Sadness/depression
- Anger Relationship issues Hunger
- Parenting difficulties Stress

After you binge, do you have feelings of self-criticism, depression or guilt?

- Yes No

Over the last 6 months, how often would you binge:

- Every day More than twice a week Never
- Occasionally Premenstrual week only Several times a month

Protein - Do You Eat The Following Foods?

Protein foods	No	Yes – how often?				Daily
		Less than 1 per week	Once per week	2-3 times per week	4-6 times per week	
Milk (skim or 1%)						
Yogurt						
Cheese						
Eggs						
Peanut butter						
Red meat (beef, pork)						
Chicken						
Legumes (beans, lentils)						
Fish						
Nuts/seeds						
Tofu						
Protein supplements and drinks						

Fluid Intake

How many caffeinated (coffee/tea) drinks do you consume daily on average: _____

How many carbonated drinks (e.g. pop, energy drinks, Perrier water, sparkling water) do you consume daily on average: _____

How much water do you drink daily on average: _____

How many fruit/vegetable drinks do you drink daily on average: _____

How much total fluids do you drink per day?

- under 750 mL 750-1200 mL 1200-1500 mL over 1500 mL

Dietary Lifestyle Changes

Please check any of the dietary/lifestyle changes you have made recently:

When did you make this change?
(days, weeks, months, years)

Quit smoking

Avoiding foods high in fat and sugar

Journaling food intake

Eating breakfast everyday

Increased water intake

Being physically active

Switched to decaffeinated coffee/tea

Eating slower

Decreased pop/diet pop intake

Other

Behavioural Programs			
Treatment	Year	How many months	How many pounds lost
Dr. Bernstein Diet and Health Clinic			
Bariatric Medical Institute (BMI)			
Emerald Program			
Jenny Craig			
TOPS			
The Ottawa Hospital Weight Management Clinic			
Strong Women Program			
Weight Watchers			
Nutrisystem			
Registered Dietitian			
Other:			

Previous Weight Management Attempts
From the 4 lists below, please check all weight management attempts you have tried in the past:

Bariatric Surgery

Treatment	Year	Where did you have your surgery	How many pounds lost
Lap band (adjustable gastric band)			
Roux-en-Y gastric bypass			
Vertical banded gastroplasty			
Duodenal switch			
Biliopancreatic diversion			
I had bariatric surgery but cannot recall what kind			

Patient:

Chart no.:

Self-Directed Diets

Treatment	Year	Dose	How many months	Reason for discontinuation	How many pounds lost
South Beach					
Atkins Diet					
GI Diet					
Glucose Revolution					
Other:					

Drugs For The Treatment Of Obesity

Treatment	Year	Dose	How many months	Reason for discontinuation	How many pounds lost
Xenical (Orlistat)					
Meridia (Sibutramine)					
Victoza (Liraglutide)					
Byetta (Extenatide)					
Other:					

Mental Health History

	Yes	No	Treatment received	Condition stable
Depression				<input type="checkbox"/> Yes <input type="checkbox"/> No
Suicidal thoughts				<input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety				<input type="checkbox"/> Yes <input type="checkbox"/> No
Bipolar disorder				<input type="checkbox"/> Yes <input type="checkbox"/> No
Schizophrenia				<input type="checkbox"/> Yes <input type="checkbox"/> No
Post-traumatic stress disorder (PTSD)				<input type="checkbox"/> Yes <input type="checkbox"/> No
Borderline personality disorder				<input type="checkbox"/> Yes <input type="checkbox"/> No
Dysthymia				<input type="checkbox"/> Yes <input type="checkbox"/> No
Attention deficit hyperactivity disorder (ADHD)				<input type="checkbox"/> Yes <input type="checkbox"/> No
Other:				<input type="checkbox"/> Yes <input type="checkbox"/> No

Patient:

Chart no.:

Health Problems	Yes	No	Unsure
Musculoskeletal pain (e.g. low back, feet or hips)			
Angina			
Heart failure			
Heart attack			
High blood pressure			
Pre-diabetes			
Diabetes			
High cholesterol			
Stroke			
Deep vein thrombosis (DVT) and/or blood clots in lungs			
Hypothyroidism			
Heartburn - gastroesophageal reflux disease (GERD)			
Ulcerative colitis, Crohn's disease			
Irritable bowel syndrome			
Celiac disease			
Undiagnosed diarrhea/constipation			
Polycystic ovarian syndrome (PCOS)			
Bladder incontinence			
Gall bladder attacks			
Liver problems (e.g. hepatitis, cirrhosis)			
Breathing problems (e.g. asthma, COPD)			
Bleeding problems (e.g. hemophilia)			
Gout or high uric acid			
Hernia (umbilical or incisional)			
Multiple Sclerosis (MS)			
History of vitamin/mineral deficiencies (e.g. iron, B12, Zinc)			
Kidney stones			
Sleep apnea			

Patient:

Chart no.:

Have you been diagnosed with diabetes?

Yes No

If no, (please skip to next section)

Have you had diabetes education in the past?

Yes No

Do you monitor your own blood sugars?

Yes No

If yes, how often do you test your blood sugars? _____

Do you take medication to control your diabetes?

Yes No

If yes, are you taking? Oral medication Insulin

Substance Use History

Tobacco:

Never smoked Occasionally smokes Less than 1/2 pack per day

More than 1/2 pack per day but less than 1 pack per day

1 pack or more per day

Ex-smoker: Please indicate when you quit smoking: _____

Alcohol use:

No alcohol use Occasionally drinks Less than 5 drinks per week

More than 5 but less than 10 drinks per week

More than 10 but less than 15 drinks per week More than 15 drinks per week

Previous issues with alcohol use but no longer drinking

Have you used street drugs or prescription drugs outside of their recommended dosage within the last 6 months: Yes No

If yes, please list:

Patient:

Chart no.:

General Medical History

Any other medical problems not yet discussed?

Any Other Surgeries	Year	Any complications

Any Routine Prescription Medications	Dose	Number of times taken daily

Any Over-The-Counter Medications	Dose	Number of times taken monthly

Patient:

Chart no.:

Vitamins/supplements (herbal and other)	Dose	Number of times taken daily

Activity/exercise History

Please indicate the amount of exercise you are doing/week:

- No extra activity or exercise right now Minimal (1 time/week)
 Moderate (less than 3 times/week) High level (more than 3 times/week)

Usual Weekly Exercise

Usual Weekly Exercise	Sessions per week (number)	Minutes per session (average)
Aerobic activity (check all that apply): <input type="checkbox"/> Swimming <input type="checkbox"/> Running <input type="checkbox"/> Squash/tennis <input type="checkbox"/> Skating <input type="checkbox"/> Aerobic classes <input type="checkbox"/> Walking <input type="checkbox"/> Cycling <input type="checkbox"/> Other specify:		
Exercise machines (check all that apply): <input type="checkbox"/> Stationary bicycle <input type="checkbox"/> Rowing machine <input type="checkbox"/> Weight lifting <input type="checkbox"/> Treadmill <input type="checkbox"/> Elliptical/stair climber <input type="checkbox"/> Other specify:		
Home activities (check all that apply): <input type="checkbox"/> House work <input type="checkbox"/> Gardening <input type="checkbox"/> Other specify:		
Sleep patterns: On average, how many hours of sleep do you get each night? What time do you normally wake up? What time do you usually go to bed? Do you have trouble falling asleep? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have trouble staying asleep? <input type="checkbox"/> Yes <input type="checkbox"/> No		

On a scale of 1 to 10, how would you rate your commitment to change your eating and lifestyle behaviours?

1 2 3 4 5 6 7 8 9 10
Somewhat committed Working to get there Really committed

What barriers or challenges do you think may prevent you from eating healthy or following a healthy lifestyle:

- Financial reasons
- Overall stress
- Child care issues
- Physical limitations limiting ability to exercise
- Work schedule
- Other (please describe):

Please Complete A 1-Day Food Diary Of A Typical Day Of Eating

Meal	Food And Fluid Intake E.g.: 1 whole grain toast, peanut butter, 1/2 banana + 1/3 cup yogurt, 1/2 cup fruit + 1 cup decaf coffee with skim milk
Breakfast Time: _____ <input type="checkbox"/> None <input type="checkbox"/> Car <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Restaurant/Food outlet	
Morning Snack Time: _____	
Lunch Time: _____ <input type="checkbox"/> None <input type="checkbox"/> Car <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Restaurant/Food outlet	
Afternoon Snack Time: _____	
Supper/Dinner Time: _____ <input type="checkbox"/> None <input type="checkbox"/> Car <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Restaurant/Food outlet	
Evening Snack Time: _____	