The Ottawa Hospital | L'Hôpital d'Ottawa

PATIENT HEALTH HISTORY
Weight Management Clinic

Date (yyyy/mm/dd)	Age	Sex ❑ F ❑ M
Referring care provider:		

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

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:

❑ No High School ❑ Some High School
❑ High School diploma ❑ Completed post-secondary
❑ Graduate studies ❑ Other

Any special needs:

❑ Visual impairment ❑ Physical impairment
❑ Hearing impairment ❑ 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):

❑ Specific life event ❑ Medical condition/illness ❑ Busy lifestyle

❑ Boredom eating ❑ Snacking/grazing ❑ Emotional/stress eating

❑ Poor understanding of healthy eating habits ❑ Lack of physical activity

❑ Unsure ❑ 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

❑ Occasionally (fewer than 2 times per month) ❑ Once a week

❑ A couple of times per week ❑ 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: ❑ Never

❑ Every day ❑ More than twice a week ❑ Several times a month

❑ Occasionally ❑ Premenstrual week only

Protein - Do You Eat The Following Foods?

Protein foods	No	Yes – how often?				
		Less than 1 per week	Once per week	2-3 times per week	4-6 times per week	Daily
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			

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				❑ Yes ❑ No
Suicidal thoughts				❑ Yes ❑ No
Anxiety				❑ Yes ❑ No
Bipolar disorder				❑ Yes ❑ No
Schizophrenia				❑ Yes ❑ No
Post-traumatic stress disorder (PTSD)				❑ Yes ❑ No
Borderline personality disorder				❑ Yes ❑ No
Dysthymia				❑ Yes ❑ No
Attention deficit hyperactivity disorder (ADHD)				❑ Yes ❑ No
Other:				❑ Yes ❑ 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			

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 ½ pack per day

❑ More than ½ 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:

_____

_____

_____

_____

_____

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

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	Sessions per week (number)	Minutes per session (average)
Aerobic activity (check all that apply): ❑ Swimming ❑ Running ❑ Squash/tennis ❑ Skating ❑ Aerobic classes ❑ Walking ❑ Cycling ❑ Other specify:		
Exercise machines (check all that apply): ❑ Stationary bicycle ❑ Rowing machine ❑ Weight lifting ❑ Treadmill ❑ Elliptical/stair climber ❑ Other specify:		
Home activities (check all that apply): ❑ House work ❑ Gardening ❑ 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? ❑ Yes ❑ No Do you have trouble staying asleep? ❑ Yes ❑ 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 ❑ Child care issues ❑ Work schedule

❑ Overall stress ❑ Physical limitations limiting ability to exercise

❑ 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, ½ banana + 1/3 cup yogurt, ½ cup fruit + 1 cup decaf coffee with skim milk
Breakfast Time: _____ ❑ None ❑ Car ❑ Home ❑ Work ❑ Restaurant/Food outlet	
Morning Snack Time: _____	
Lunch Time: _____ ❑ None ❑ Car ❑ Home ❑ Work ❑ Restaurant/Food outlet	
Afternoon Snack Time: _____	
Supper/Dinner Time: _____ ❑ None ❑ Car ❑ Home ❑ Work ❑ Restaurant/Food outlet	
Evening Snack Time: _____	