Capital Health

THE LP SURGERY ASSESSMENT

<table>
<tr><td colspan="2">Date:</td></tr>
<tr><td colspan="2">Name:</td></tr>
<tr><td colspan="2">Health Card Number (and expiry date):</td></tr>
<tr><td>DOB:</td><td>Age:</td></tr>
<tr><td>Address:</td><td>Phone: (work):
(home):
Do you give permission for the team to leave voice mail messages? Yes ☐ No ☐</td></tr>
<tr><td colspan="2">E-Mail address:</td></tr>
<tr><td colspan="2">Family Doctor / Nurse Practitioner:</td></tr>
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****Have you had Weight Loss Surgery Before?** Yes ☐ No ☐
If Yes, stop here and see a staff/facilitator now**

Health Assessment (check all that apply)

☐ HEIGHT______________

☐ WEIGHT______________

☐ Trial of multiple diets in the past: Yes ☐ No ☐

List at least 3:____

Most weight lost______________ on which diet____________________________________

☐ High Blood Pressure Date of Dx (year):___________________________________

☐ Enlarged Heart Date of Dx (Year):____

☐ PreDiabetes or Type 2 DM Date of Diagnosis (year)__________________________

☐ Reflux Date of Diagnosis (year)__________________________

☐ Sleep Apnea Date of Diagnosis (year)__________________________

Do you use a c-pap or other device: Yes ☐ No ☐

- ☐ Disabling arthritis, chronic low back pain, osteoarthritis (where is your pain—
  describe:____
- ☐ Awaiting knee or hip replacement ____________________________________
- ☐ Skin breakdown secondary to excess weight (where): __________________________________
- ☐ High cholesterol or triglycerides: Date of Diagnosis (year)_____________________
- ☐ Fatty liver: Date of Diagnosis (year)_____________________
- ☐ Past history of anorexia or bulimia: When:_______________________________________
- ☐ Asthma or other breathing challenges Date of Dx (year):________________________________
- ☐ History of heart attack, angina or stroke: Details _______________________________________
- ☐ Depression: Date of Diagnosis (year)_______________ On medication?_________________
  - ☐ Who follows you?__________________
  - ☐ History of suicide attempts?_________________
  - ☐ History of Physical Abuse?_____________________
  - ☐ History of Sexual Abuse?_______________________
  - ☐ History of Binge Eating?________________________
  - ☐ History of Skipping Meals?______________________
  - ☐ History of drug or alcohol abuse?_________________________
- ☐ Thyroid disease Diagnosis Year:________________________________
- ☐ Other syndromes (list them)____

Surgical History (list all previous surgeries):_______________________________________
____
____
____

Do You Have A Gall Bladder?____

What **Medications** Do You Take?

Name Of Medication	Dose	When You Take It	What It Is For
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			

Allergies:____
____

Eating

Describe what you eat on a typical day (meals, snacks, liquids)

Breakfast	Mid Afternoon Snack
Mid Morning Snack	Supper
Lunch	Evening Snack

Please circle Y (Yes) or N (No) as appropriate:

Do you drink juice? Y or N How much? ____________________

Do you drink pop? Y or N How much? ____________________
Diet or Regular? ____________________

Do you chew gum? Y or N How often? ____________________

Do you drink alcohol? Y or N How much? ____________________
How often? ____________________

How many times/week do you eat out or buy take out (include drive throughs, cafeterias, restaurants, Tim Horton's, Pizza, McDonalds, etc)?____
____

Do you eat when stressed? Y or N

Do you eat when bored? Y or N

What foods do you eat too much? (circle all that apply):
(chips, cheesies, salty snacks) (chocolate, candy) (cookies, cakes, pies, pastries)

Do you drink coffee? Y or N (circle all that apply) with milk, with cream, sugar, black

Do you drink milk? Y or N How much? ________________________________

Do you eat breakfast? Y or N

Do you have food allergies? Y or N

What do you think are 3 significant contributing factors to your obesity?

1.________________________ 2.______________________ 3.____________________________

Do you **exercise**? Y or N What do you do:_____________________________________

--or……. Why do you not exercise? ____

Do you **smoke**? Y or N What do you smoke (cigarettes, cigars, street drugs)
How much?____

Do you **work** outside the home? Y or N What is your job/where do you work?______
____

Do you have a health plan? Y or N Which company?_______________________

Who are the supportive people in your life? ____

Do they support your decision for Weight Loss Surgery? Y or N

Stressors in your life?____

Have you been on the CDHA Obesity Network Website? Y or N.
Assembled a binder? Y or N.
Studied it? Y or N.
Have you completed the quiz? Y or N

Why do you want this surgery?____
____
____
____

Please check one of the following:

☐ Yes….I want this surgery.
☐ No…..I do not want this surgery at this point.

Things I plan to do before the next clinic:____

____
____
____

Signature:____

Date:____

Other info we should know: