WLS Patient Health History (LP)

Personal Information

Date:
Name:
Health Card Number (and expiry date):
DOB:
Age:
Address:
Phone (work): (home):
Do you give permission for the team to leave voice mail messages?
E-Mail address:
Family Doctor / Nurse Practitioner:

Health Assessment

Height:
Weight:
BMI:
Waist Circumference:

How long have you been challenged with your weight? Age 10 or <, 11-19, >19 (circle)
List three diets you have tried in the past:
On which diet did you lose the most weight?
How much weight did you lose?
Have you had Weight Loss Surgery before?

Health History (check all that apply)

☐ High Blood Pressure
☐ Enlarged Heart
☐ Prediabetes or Type 2 Diabetes
☐ Reflux
☐ Sleep Apnea Do you use a c-pap or other device?
☐ Disabling arthritis, chronic low back pain, osteoarthritis
☐ Awaiting knee or hip replacement

☐ Skin breakdown secondary to excess weight (where?)
☐ High cholesterol or triglycerides
☐ Fatty liver
☐ Thyroid disease
☐ History of anorexia or bulimia
☐ Asthma or other breathing challenges
☐ History of heart attack, angina, or stroke
☐ Depression 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
☐ Other syndromes (please list)

Surgical History (please list and include year of surgery):

Do You Have a Gall Bladder?

Medication History

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 (please list):

Food History

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

Breakfast	Mid Afternoon Snack
Mid-Morning Snack	Supper
Lunch	Evening Snack

Do you drink juice? How much?
Do you drink pop? Diet or Regular? How much?
Do you chew gum? How often?
Do you drink alcohol? How much? How often?

How many times a week do you eat out or buy take out?
Do you eat when stressed?
Do you eat when bored?
What foods do you eat too much?
Do you drink coffee? With milk, cream, sugar, black (circle all that apply)
Do you drink milk? How much?
Do you eat breakfast?
Do you have food allergies?

Psychosocial History

What do you think are 3 significant contributing factors to your obesity?
1.
2.
3.

Do you exercise?
If yes, list what you do:
If no, explain why not:
Do you smoke? Cigarettes, cigars, cannabis (circle all that apply)
How much?
Do you work?
What is your job/where do you work?

Do you have a health plan? Which company?
Who are the supportive people in your life?
Do they support your decision for Weight Loss Surgery?
What are the stressors in your life?

Program Preparation

Have you been on the Halifax Obesity Network Website?
Have you assembled a binder?
Have you studied it?
Have you completed the quiz?
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: