Return within 6 weeks MAXIMUM

Centre intégré de santé et de services sociaux de la Côte-Nord
Québec

File No.

Full name at birth

Date of birth (YYYY-MM-DD)

INTERDISCPLINARY BARIATRIC CLINIC QUESTIONNAIRE EVALUATION OF YOUR PHYSICAL, PSYCHOSOCIAL AND NUTRITIONAL HEALTH CONDITION

DESTROY WHEN THE USER LEAVES (AFTER SERVICE PROVISION)

Please complete ALL sections so we can properly evaluate your file. Thank you.

GENERAL INFORMATION

Last name: _____ Date of birth: _____

First name: _____ Health insurance card number: _____

Address: _____ Town: _____

Province: _____ Postal code: _____

Telephone: Home: _____ Work: _____ Cellphone: _____

Email: _____

Referring physician: _____ The referring physician is my family physician ☐ Yes ☐ No

Address of their clinic: _____

Were you ever on a waiting list for, or did you go through a surgery related to obesity? ☐ No ☐ Yes (complete the archive request)

If yes, date: _____ Name of the surgeon who operated on you: _____

In what field are you working or studying? _____

INFORMATION ON YOUR HEALTH CONDITION

Weight: _____ lb or _____ kg Height: _____ feet _____ inches or _____ centimetres

Check the boxes corresponding to your health condition. Add comments if needed.

Diabetes

Are you diabetic? ☐ Yes ☐ No If yes, since when: _____

If **yes**, do you test your blood sugar? ☐ Yes ☐ No

☐	You have early diabetes treated by a diet (No medication currently)
☐	Your diabetes is only treated with oral medication
☐	Your diabetes is treated with insulin, with or without oral medication

Comments: _____

Sleep apnea

☐	Possible if you have one of these symptoms (important snoring, daytime sleepiness, frequent awakenings at night, sleepy in the morning)
☐	Diagnosed but you are not using the prescribed device Reason for not using the device: _____
☐	Diagnosed and you are using the prescribed device (CPAP or BiPAP) ☐ Yes ☐ No If **yes**, get a copy of your compliance report to complete your file

Comments: _____

Name:	File No.:

Heart disease	
☐	A physician has confirmed that you have angina
☐	A physician has confirmed that you have heart rhythm disorders (arrhythmia)
☐	You have gone through heart surgery in the past (bypass, heart-valve replacement)
☐	You have had dilatation or tutors inserted with cardiac catheterization (coronarography)

Comments: _____

_____

Orthopedic problems	
☐	You are able to walk without walking aids (cane, walker). You are autonomous in your daily activities and you can climb stairs.
☐	You walk using a walking aid (cane, walker) **or**, you need frequent help in your daily activities **or**, you have received or are still receiving infiltrations, or you have used or are still using narcotics or anti-inflammatory medication to treat muscle or joint pain (back, knees, ankles, etc.).
☐	You have received a total disability diagnosis **or** you are waiting for an orthopedic surgery (back, knees, hip) **or** you must use a wheelchair to get around.

Comments: _____

_____

Family history	
☐	Family members are also known or followed for morbid obesity

If **yes**, name them and give a short description of their condition: _____

_____

_____

HEALTH CONDITIONS NOT MENTIONED ABOVE

Please specify: _____

_____

SOCIODEMOGRAPHIC INFORMATION

☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Common-law partner ☐ Indigenous

Number of children and age: _____

Source of income: ☐ Work ☐ Social assistance ☐ CNESST ☐ SAAQ
☐ Disability benefit ☐ Retired ☐ Other: _____

Financial problems ☐ Yes ☐ No If **yes**, please specify: _____

_____

Type of housing: ☐ House ☐ Apartment ☐ Condo ☐ Room ☐ Other _____

Living with: _____

What is this person's relation to your children? _____

PSYCHOSOCIAL HISTORY

☐	You have had one or many depressive episodes that did not require the use of antidepressants.
☐	You have had one or many depressive episodes that required or still require the use of antidepressants.

Psychiatrist ☐ Yes ☐ No

If **yes**, for what reason(s), and in what year: _____

_____

Name:	File No.:

PSYCHOSOCIAL HISTORY (CONTINUED)

Psychologist ☐ Yes ☐ No
If **yes**, for what reason(s) and in what year: _____

Social worker or psychoeducator ☐ Yes ☐ No
If **yes**, for what reason(s) and in what year: _____

Were you ever hospitalized for mental health reasons? ☐ Yes ☐ No
If **yes**, for what reason(s) and in what year: _____

Are you or have you ever been in conflict with the law? ☐ Yes ☐ No
If **yes**, for what reason(s) and in what year: _____

Are you or have you ever been in conflict with the DPJ? ☐ Yes ☐ No
If **yes**, for what reason(s) and in what year: _____

LIFESTYLE HABITS

Waking time: Bedtime:

Number of naps: Duration of the nap(s):

Daily hours of internet use:

Trouble with:

Hygiene ☐ Yes ☐ No Mobility ☐ Yes ☐ No Meals ☐ Yes ☐ No

Using the toilet ☐ Yes ☐ No Housework ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No You are required to stop using tobacco before the surgery.
If **yes**, in what amounts? Daily: _____ Weekly: _____ Monthly: _____

Do you drink alcohol? ☐ Yes ☐ No
If **yes**, in what amounts? Daily: _____ Weekly: _____ Monthly: _____

Do you consume hard drugs? ☐ Yes ☐ No
If **yes**, in what amounts? Daily: _____ Weekly : _____ Monthly: _____

Additional information: _____

WEIGHT GAIN HISTORY

At what age did you start gaining weight?

Did you ever gain 100 lb in 5 years or less? ☐ Yes ☐ No

As an adult:
Maximum weight: _____ lb or _____ kg
Minimum weight: _____ lb or _____ kg

Weight maintained for the longest time: _____ lb or kg

DIET HISTORY

Have you ever followed a diet? ☐ Yes ☐ No
If **yes**, specify: _____

Are you currently following a diet? ☐ Yes ☐ No
If **yes**, which one: _____

Have you met with a nutritionist? ☐ Yes ☐ No
If **yes**, why: _____

Name:	File No.:

DIETARY HISTORY

Do you eat three meals per day: ☐ Yes ☐ No **Check the boxes:** ☐ Breakfast ☐ Lunch ☐ Supper

Do you eat between meals? ☐ Yes ☐ No If **yes**, how many times per day: _____

Check the food categories you consume every day:

☐ Fruits ☐ Vegetables ☐ Dairy products ☐ Starchy foods ☐ Meat

Do you eat sweet desserts? ☐ Yes ☐ No

If **yes**, in what amounts? Daily: _____ Weekly: _____ Monthly: _____

Do you eat chips? ☐ Yes ☐ No

If **yes**, in what amounts? Daily : _____ Weekly: _____ Monthly : _____

Do you eat chocolate? ☐ Yes ☐ No

If **yes**, in what amounts? Daily: _____ Weekly: _____ Monthly: _____

Do you eat fries or fried foods? ☐ Yes ☐ No

If **yes**, in what amounts? Daily: _____ Weekly: _____ Monthly: _____

Do you sometimes take a second serving of a meal? ☐ Yes ☐ No

Do you sometimes eat during the night? ☐ Yes ☐ No

Do you sometimes eat without being hungry? ☐ Yes ☐ No

Do you sometimes drink soft drinks? ☐ Yes ☐ No ☐ Diet ☐ Regular

If **yes**, in what amounts? Daily: _____ Weekly: _____ Monthly: _____

How long does a meal usually take you?

How often do you go to the restaurant in a week?

What types of restaurant do you usually go to? ☐ Fast food ☐ Family (menu) ☐ Buffet

Do you sometimes feel “too full” after meals? ☐ Yes ☐ No

Do you sometimes feel like you are losing control when eating certain foods? ☐ Yes ☐ No

EXPERIENCES / EXPECTATIONS / MOTIVATIONS

Do you know people who went through bariatric surgery? ☐ Yes ☐ No

If yes, give us a few details: _____

What are your expectations and motivations for going through surgery, aside from weight loss?

RETURN THE QUESTIONNAIRE TO THIS ADDRESS:

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