INSTITUT UNIVERSITAIRE DE CARDIOLOGIE ET DE PNEUMOLOGIE DE QUÉBEC

IUCPQ Bariatric Surgery Program Health Questionnaire

General information IUCPQ file no.:

Last name (Maiden): _____ **Date of birth:** _____

First name: _____ **Health insurance card number:** _____

Address: _____ **City:** _____

Province: _____ **Postal code:** _____

Phone (home): _____ **Phone (work):** _____

Cellular: _____ **Other:** _____

Email: _____

Name of referring physician: _____

Address of clinic: _____

Have you ever had surgery for obesity? **Yes** ☐ **No** ☐

If you answered Yes, give the date and the name of the surgeon: _____

Specify your profession or whether you are a student: _____

Health information

Weight: _____ **lb** _____ **kg** **Height:** _____ **feet, inches** _____ **metres**

Check the statement that best describes your health and add comments as needed

Diabetes	
☐	Your diabetes is recent and is being treated with diet (no medication for the moment)
☐	Your diabetes is being treated with medication alone
☐	Your diabetes is being treated with insulin with or without medication
Comments:	
Sleep apnea	
☐	Possible because you have one of the following symptoms: severe snoring, daytime sleepiness, waking up frequently at night, fatigue after waking
☐	Diagnosed but you do not use the prescribed device. Reason for not using the device:

☐	Diagnosed and you use the prescribed device (CPAP or BPAP)
Comments:	
Heart disease	
☐	A physician has confirmed that you have angina
☐	A physician has confirmed that you have arrhythmia
☐	You have had heart surgery (bypass, valve replacement)
☐	You have had dilatations or stents via cardiac catheterization
Comments :	
Orthopedic problems	
☐	You can get around without a mobility aid (cane, walker), you are autonomous in your daily activities and you can climb the stairs
☐	You get around with a mobility aid (cane, walker) or you frequently need help with your daily activities or you have received or continue to receive injections of narcotic or anti-inflammatory medications to treat joint pain (back, knees, ankles, etc.)
☐	You have been diagnosed with a total incapacity or you are waiting to undergo orthopedic surgery (back, knees, hips) or you require a wheelchair to get around
Comments :	
Quality of life	
☐	You have had one or more depressive episodes that did not require the use of antidepressants
☐	You have had one or more depressive episodes that required or still require the use of antidepressants
☐	You have problems with your personal hygiene because of your obesity
Health conditions not mentioned above	

INSTITUT UNIVERSITAIRE DE CARDIOLOGIE ET DE PNEUMOLOGIE DE QUÉBEC

IUCPQ Bariatric Surgery Program Psychosocial Questionnaire

General information IUCPQ file no.:

Last name (Maiden): _____ **Date of birth:** _____

First name: _____ **Health insurance card number:** _____

Address: _____ **City:** _____

Province: _____ **Postal code:** _____

Phone (home): _____ **Phone (work):** _____

Cellular: _____ **Other:** _____

Email: _____

Name of referring physician: _____

Address of clinic: _____

Have you ever had surgery for obesity? **Yes** ☐ **No** ☐

If you answered Yes, give the date and the name of the surgeon: _____

Specify your profession or whether you are a student: _____

Informations sociodémographiques

Married ☐	Single ☐	Separated ☐	Divorced ☐	Widowed ☐	Common law ☐
Number of children and age(s):					
Source of income:	Employed ☐ Disability benefits ☐	Social assistance ☐ Retired ☐	CNESST ☐ Other ☐	SAAQ ☐	
Financial problems			Yes ☐	No ☐	
If you answered **Yes**, explain					
Type of dwelling: House ☐	Apartment ☐	Condo ☐	Room ☐	Other ☐	
You live with:					
What is this person's relationship with your children?					

Psychosocial and legal history

Have you ever been assessed or treated by a:

Psychiatrist	Yes ☐	No ☐
If you answered **Yes**, give the **reason(s)** and **year(s)**		

Psychologist	Yes ☐	No ☐
If you answered **Yes**, give the **reason(s)** and **year(s)**.		
Social worker or psychoeducator	Yes ☐	No ☐
If you answered **Yes**, give the **reason(s)** and **year(s)**.		
Have you ever been hospitalized for mental health reasons? If you answered **Yes**, give the **reason(s)** and **year(s)**.	Yes ☐	No ☐
Do you have or have you ever had legal problems?	Yes ☐	No ☐
Do you have or have you ever had a file with youth protection authorities?	Yes ☐	No ☐
Do you consume alcohol or drugs?	Yes ☐	No ☐
If you answered **Yes**, give the quantity per week.		

Life habits

Time you get up:	Time you go to bed:
Number of nap(s):	Duration of nap(s):
Number of hours of Internet per day:	

Problem(s) with:

Hygiene:	Yes ☐	No ☐	Mobility:	Yes ☐	No ☐
Going to bathroom:	Yes ☐	No ☐	Household chores:	Yes ☐	No ☐
Meals:	Yes ☐	No ☐			

Do you receive help from the CLSC?	Yes ☐	No ☐
If you answered **Yes**, specify.		

What are your activities during the week (day and night)?

What are your expectations and reasons for undergoing surgery, aside from losing weight?

Additional information:

INSTITUT UNIVERSITAIRE DE CARDIOLOGIE ET DE PNEUMOLOGIE DE QUÉBEC

IUCPQ Bariatric Surgery Program Nutritional Questionnaire

General information IUCPQ file no.:

Last name (Maiden): _____ **Date of birth:** _____

First name _____ **Health insurance card number:** _____

Address: _____ **City:** _____

Province: _____ **Postal code:** _____

Phone (home): _____ **Phone (work):** _____

Cellular: _____ **Other:** _____

Email: _____

Name of referring physician: _____

Address of clinic: _____

Have you ever had surgery for obesity? **Yes** ☐ **No** ☐

If you answered Yes, give the date and the name of the surgeon: _____

Specify your profession or whether you are a student: _____

Weight history

At what age did you begin to have problem with your weight?			
Have you ever gained 100 pounds over 5 years period or less?		Yes ☐	No ☐
As an adult:	Maximum weight:	_____ kg or _____ lb	
	Minimum weight:	_____ kg or _____ lb	

Diet history

Have you ever been on a diet?	Yes ☐	No ☐
If you answered **Yes**, specify the diet(s).		
Are you currently on a diet?	Yes ☐	No ☐
If you answered **Yes**, specify the diet.		
Have you ever seen a dietitian?	Yes ☐	No ☐
If you answered **Yes**, explain why.		

Eating habits

Every day, do you have:		
Breakfast	Yes ☐	No ☐

Lunch	Yes ☐	No ☐
Dinner	Yes ☐	No ☐
Do you eat between meals?	Yes ☐	No ☐
If you answered **Yes**, how many times per day? _____		

Every day, do you have:			**Do you have:**			
	Yes	No		Never	Daily	Weekly
Fruit	☐	☐	Desserts	☐	☐	☐
Vegetables	☐	☐	Chips	☐	☐	☐
Milk products	☐	☐	Chocolate	☐	☐	☐
Starches (patatos, rice, pasta, bread...)	☐	☐	Fries/fried foods	☐	☐	☐
Meat	☐	☐				

Do you sometimes have a second serving?	Yes ☐	No ☐
Do you eat during the night?	Yes ☐	No ☐
Do you drink alcohol?	Yes ☐	No ☐
If you answered **Yes**, give the quantity. Per day: _____	Per week: _____	
Do you use drugs?	Yes ☐	No ☐
If you answered **Yes**, give the quantity. Per day: _____	Per week: _____	
Do you drink soft drinks?	Yes ☐	No ☐
If you answered **Yes**, give the quantity. _____	Diet ☐ and/or Regular ☐	
How long does a typical meal last?		
How many times per week do you eat at a restaurant?		
What is your usual restaurant choice? Fast food: ☐	Family (menu): ☐	Buffet : ☐
Are you sometimes unable to stop eating?	Yes ☐	No ☐

Diabetes

Are you diabetic?	Yes ☐	No ☐
If you answered **Yes**, do you measure your	Yes ☐	No ☐

Expectations and reasons

What are your expectations and reasons for undergoing surgery, aside from losing weight?

SUBMIT QUESTIONNAIRES