

Toronto Minimally Invasive Surgery Group

Information about Minimally Invasive Surgery for Referring Physicians and Patients

Preoperative Patient Questionnaire

Please complete this questionnaire as completely and accurately as you can. In order to process your information, we will also need a referral from your family physician or specialists. Please pay be sure to include accurate information about any previous operations you have had.

Personal Details

Last Name: _____ First Name: _____

Address: _____

_____ Postal Code: _____

Home phone number: _____ Work phone number: _____

Mobile number: _____

Date of birth: _____ Age: _____

OHIP number: _____ Version Code: _____

Recent accurate weight: _____ (lbs or kg) Recent accurate height: _____ (cm or ft,inches)

I am primarily interested in the:

Laparoscopic Gastric Bypass operation

Laparoscopic Gastric Band operation

Undecided

Contact Information

Next of Kin

Name: _____ Relationship: _____

Address: _____

Home phone number: _____ Work phone number: _____

Additional Contact

Name: _____ Relationship: _____

Address: _____

Home phone number: _____ Work phone number: _____

Referring Physicians

Referring doctor: _____ Referral date: _____

Address: _____

Phone number: _____ Fax number: _____

Family doctor (if different) _____

Address: _____

Phone number: _____ Fax number: _____

Specialist: _____ Specialty: _____

Address: _____

Phone number: _____ Fax number: _____

Social Profile

Marital Status

Single: Married:

Divorced/separated: Partner/Relationship:

Number of children: _____ Age of youngest child: _____

Who is available to provide support during your recovery: _____

Medical History

Cardiovascular

| Diagnosis | Present | Description/Explanation |
|----------------------|--------------------------|-------------------------|
| Heart Problems | <input type="checkbox"/> | |
| Irregular heart beat | <input type="checkbox"/> | |
| Chest pain/tightness | <input type="checkbox"/> | |

| | | |
|-------------------------|--------------------------|--|
| Shortness of breath | <input type="checkbox"/> | |
| Poor exercise tolerance | <input type="checkbox"/> | |
| High cholesterol | <input type="checkbox"/> | |
| High triglycerides | <input type="checkbox"/> | |
| Poor energy | <input type="checkbox"/> | |

Endocrine

Diabetes Mellitus: Type 1, Type 2

How long have you had diabetes: _____

How long have you been taking oral diabetic medication: _____

How long have you been taking insulin: _____

Do you have any complications of diabetes:

Kidney damage Eye problems Poor circulation Peripheral neuropathy

Other: _____

Other: _____

Thyroid problems: Yes, Medications? _____

Have you been diagnosed with polycystic ovarian syndrome (PCOS): Yes, Details: _____

Gastrointestinal

Gallstones:

Gallstones: - Yes, - No

If yes, then have they caused pain: - Yes, - No

If yes, then have you had surgery (cholecystectomy): - Yes, - No

If yes, then was the surgery - Open or Laparoscopic

Stomach ulcers:

Have you ever had a stomach or duodenal ulcer: - Yes, - No

If yes, what medications did/do you take? _____

If yes, did you have surgery for stomach ulcers, please describe: _____

Heartburn (gastroesophageal reflux):

Do you suffer from heartburn? - Yes, - No

If yes, how often: _____

What medications do you use: _____

Respiratory

Asthma:

Do you have asthma: Yes, No

If yes, when was your last attack: _____

How often do you have an attack: _____

Have you ever had bronchitis: Yes, details: _____

Have you ever had pneumonia: Yes, details: _____

Have you ever had a blood clot in your lung: Yes, No

Have you ever had a blood clot in your leg: Yes, No

How far can you walk without getting short of breath: _____

Can you climb a flight of stairs without stopping: Yes, No

If no, what makes you stop: _____ -

Do you have sleep apnea: Yes, No

If yes, do you use a CPAP machine: Yes, No

Do you snore excessively: Yes, No

Do you have trouble staying awake during the day: Yes, No

Do you feel well rested when you wake up in the morning: Yes, No

Has anyone noticed that you briefly stop breathing while you sleep: Yes, No

Musculoskeletal

| | Mild | Moderate | Severe |
|-----------------|--------------------------|--------------------------|--------------------------|
| Hip Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Knee Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ankle Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Foot Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Back Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Neck Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Do you use anti-inflammatory medications: Yes, No

Do you have swelling of you legs or feet: Yes, No

Do you have varicose veins: Yes, No

Kidney and Bladder

Do you spill urine when coughing or laughing: Yes, No

Have you had kidney or bladder infections: Yes, No

Have you had kidney stones: Yes, No

Blood

Have you ever had a bleeding problem: - Yes, - No

Have you ever had low platelets: - Yes, - No

Have you ever had a blood transfusion: - Yes, - No

Do you have a history of hepatitis: - Yes, - No

Psychological Health

Do you suffer from depression: - Yes, - No

If yes, do you think it is from obesity: - Yes, - No

Do you take medication for depression: - Yes, - No

Do you or have you had seizures: - Yes, - No

If yes, do you take anti-seizure medication regularly: - Yes, - No

Do you have a history of alcohol abuse: - Yes, - No

If yes, how long have you been sober: _____

Do you have a history of drug abuse: - Yes, - No

If yes, how long have you been clean: _____

Do you suffer from bulimia: - Yes, - No

Do you have an eating disorder: - Yes, - No

Surgical History

Please list all operations that you have had and any complications that occurred. Please be sure to pay particular attention to any operations on your abdomen.

| Operation | Date | Coment |
|-----------|------|--------|
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Medication History

| Medication | Dose | Frequency | For What Condition |
|------------|------|-----------|--------------------|
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Medical Allergies

Please list all medication allergies:

| Drug | Reaction |
|------|----------|
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| | |
| | |
| | |

Family Medical History

| | Parent | Child/Sibling | Other Relative | No Family History | Don't Know |
|----------------------------|--------|---------------|----------------|-------------------|------------|
| Diabetes | | | | | |
| Heart Disease | | | | | |
| High Blood Pressure | | | | | |
| Gout | | | | | |
| Gall Stones | | | | | |
| Obesity | | | | | |
| Snoring/Sleep Apnea | | | | | |
| Asthma | | | | | |
| Allergies | | | | | |
| Skin Conditions | | | | | |
| High Cholesterol | | | | | |
| Osteoporosis | | | | | |

| | Parent | Child/Sibling | Other Relative | No Family History | Don't Know |
|------------------------------------|---------------|----------------------|-----------------------|--------------------------|-------------------|
| Bleeding/clotting Disorders | | | | | |
| Cancer | | | | | |

Weight and Dieting

Weight History

Please indicate how you remember your weight at the following times in your life:

| | Below Average | Average | Above Average | Obese |
|--------------------------------------|----------------------|----------------|----------------------|--------------|
| Beginning school (5-6 years) | | | | |
| Beginning high school (14-15 years) | | | | |
| End of high school (17-19 years) | | | | |
| At age 21 | | | | |
| At age 30 | | | | |
| At age 40 | | | | |

Dieting - Non-Supervised

| Diet Name | Tried | Weight Lost | Diet Name | Tried | Weight Lost |
|------------------|--------------------------|--------------------|------------------|--------------------------|--------------------|
| Grapefruit Diet | <input type="checkbox"/> | | Atkins | <input type="checkbox"/> | |
| South Beach | <input type="checkbox"/> | | Body For Life | <input type="checkbox"/> | |

| Diet Name | Tried | Weight Lost | Diet Name | Tried | Weight Lost |
|------------------|--------------------------|-------------|------------------|--------------------------|-------------|
| Slim Fast | <input type="checkbox"/> | | Calorie Counting | <input type="checkbox"/> | |
| Mayo Clinic Diet | <input type="checkbox"/> | | | <input type="checkbox"/> | |
| (others) | <input type="checkbox"/> | | | <input type="checkbox"/> | |
| | <input type="checkbox"/> | | | <input type="checkbox"/> | |

Dieting - Supervised

| Diet Name | Tried | Weight Lost | Diet Name | Tried | Weight Lost |
|-----------------|--------------------------|-------------|----------------------|--------------------------|-------------|
| Weight Watchers | <input type="checkbox"/> | | Jenny Craig | <input type="checkbox"/> | |
| Dietitian | <input type="checkbox"/> | | Physician Supervised | <input type="checkbox"/> | |
| Acupuncture | <input type="checkbox"/> | | Overeaters Anonymous | <input type="checkbox"/> | |
| Nutri-Systems | <input type="checkbox"/> | | Optifast | <input type="checkbox"/> | |
| T.O.P.S | <input type="checkbox"/> | | Dr. Lance Levy | <input type="checkbox"/> | |
| (others) | <input type="checkbox"/> | | | <input type="checkbox"/> | |

Dieting - Medications

Please list any medications you have tried and how much weight you were able to lose:

Life Events

Please list any events in your life that led to significant weight gain or loss:

| Event Description | Gain/Loss | Amount |
|-------------------|--|--------|
| | <input type="checkbox"/> Gain, <input type="checkbox"/> Loss | |
| | <input type="checkbox"/> Gain, <input type="checkbox"/> Loss | |
| | <input type="checkbox"/> Gain, <input type="checkbox"/> Loss | |
| | <input type="checkbox"/> Gain, <input type="checkbox"/> Loss | |
| | <input type="checkbox"/> Gain, <input type="checkbox"/> Loss | |

Please list any other weight loss techniques you have tried (such as acupuncture, hypnosis, etc)

Current Weight Status

Over the last year have you:

Gained weight: Amount: _____

Lost weight: Amount: _____

Weight has remained stable.

Over the last three months have you:

Gained weight: Amount: _____

Lost weight: Amount: _____

Weight has remained stable.