TRURO OBESITY CARE TEAM
Colchester East Hants Health
Centre 600 Abenaki Rd., Truro, NS
Phone: (902) 673-3211
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PATIENT INTAKE FORM

Date (yyyy-mm-dd): _____

GENERAL INFORMATION

Name: _____ Health Card No: _____

Date of Birth (yyyy/mm/dd): _____ Age: _____

Address: _____

Phone (cell): _____ Phone (work): _____

Phone (other): _____

Do you give permission for the team to leave voicemail? ☐ **YES** ☐ **NO**

Email: _____

Family Doctor/ Nurse Practitioner: _____

HEALTH HISTORY

Weight:	lb,	kg	Height:	ft in,	m
BMI:			Waist:	in	

Check what corresponds to your state of health, add comments if necessary

Diabetes:

- ☐ You have prediabetes treated with diet (no medication at the moment)
- ☐ Your diabetes is treated only with tablets
- ☐ Your diabetes is treated with insulin with or without tablets

Comments: _____

Sleep Apnea:

- ☐ Possible if you have one of these symptoms (heavy snoring, drowsiness during the day frequent awakenings at night, fatigue upon waking)
- ☐ Diagnosed but not wearing prescribed device

Reason you are not wearing the device: _____

- ☐ Diagnosed and you are wearing the prescribed device (CPAP or BPAP)

Comments: _____

Cardiac disease:

- ☐ A doctor has confirmed that you have angina
- ☐ A doctor has confirmed that you have heart rhythm problems (arrhythmia)
- ☐ You have already had heart surgery (bypass, valve replacement)
- ☐ You have had cardiac catheterization, dilations or stents
- ☐ Diagnosed with high blood pressure.
- ☐ Other heart conditions: _____

Comments: _____

Orthopaedic problems:

- ☐ You are able to move around without a walking aid (cane, walker), you are independent in your daily activities and able to climb stairs.
- ☐ You move around using a walking aid (cane, walker) or need help frequently in daily activities or have had or still use infiltrations with narcotic or anti-inflammatory medications to treat joint pain (back, knees, ankle, etc.)
- ☐ You have been diagnosed with total disability or are awaiting orthopaedic surgery (back, knees, hip) or you must use a wheelchair.

  Comments: _____

Other Conditions:

- ☐ High Cholesterol or Triglycerisdes
- ☐ Fatty Liver
- ☐ Thyroid Disease
- ☐ Acid Reflux (GERD)

Have you had previous weight-loss surgery? ☐ **YES** ☐ **NO**

If yes, please provide type, name of surgeon, date, weight outcomes:

Do you have a Gallbladder? ☐ **YES** ☐ **NO**

Medication History

Medication Name	*Dose*	*Taken When*	*Taken For*

Do you have any allergies? ☐ **YES** ☐ **NO** If yes, list:

DIET/FOOD HISTORY

When did your weight challenges begin? Age (years) ☐ **9 or less** ☐ **11-19** ☐ **19 or older**

Which diets have you tried? _____

On which diet did you lose the most weight? _____

How much weight did you lose? _____

Name of diet currently following, if any: _____

Have you ever met with a Nutritionist/Dietitian? ☐ **YES** ☐ **NO**

If yes, why?

Which meals do you eat everyday? Breakfast: ☐ **YES** ☐ **NO**

Lunch: ☐ **YES** ☐ **NO**

Supper: ☐ **YES** ☐ **NO**

Do you eat between meals? ☐ **YES** ☐ **NO** If yes, how many per day? _____

Which do you eat EVERY day? Check all that apply.

☐ Fruits ☐ Vegetables ☐ Dairy Products

☐ Meat ☐ Starch (carbs) ☐ Sweet Desserts

☐ Potato Chips ☐ Chocolate ☐ Fries

Do you ever have a second serving of food at a meal? ☐ **YES** ☐ **NO**

Do you ever eat at night? ☐ **YES** ☐ **NO**

Do you drink soft drinks? ☐ **YES** ☐ **NO** If yes: ☐ **REGULAR** or ☐ **DIET**

If yes, how many per day? _____

Do you drink juice? ☐ **YES** ☐ **NO** If yes, how many per day? _____

Do you chew gum? ☐ **YES** ☐ **NO** If yes, how many per day? _____

Do you drink coffee? ☐ **YES** ☐ **NO** If yes, list what you put in it? _____

Do you drink milk? ☐ **YES** ☐ **NO** If yes, how much per day? _____

Do you eat fast food? ☐ **YES** ☐ **NO** If yes, how often per week: _____ .

Do you eat at Restaurants? ☐ **YES** ☐ **NO**

If yes, list types and how often per week:

PSYCHOSOCIAL HISTORY

Are you working? ☐ **YES** ☐ **NO**

What is your job and where do you work? _____

Do you have a health plan? ☐ **YES** ☐ **NO** If yes, which company? _____

Marital status: _____

Do you drink alcohol? ☐ **YES** ☐ **NO** If yes, how many drinks per day? _____

How many per week? _____

Do you **smoke**? ☐ **YES** ☐ **NO** If yes, how many per week? _____

If yes, check type(s) & how often:

	☐ Cigarettes	☐ Cigars	☐ Cannabis	☐ Vapes
How Often?				

Do you use any drugs? ☐ **YES** ☐ **NO** If yes, list drugs and how often:

Do you Exercise? ☐ **YES** ☐ **NO** If yes, list types of exercise/frequency **OR** if not, explain why:

What do you feel are the 3 contributing factors to your obesity?

What are the stressors in your life?

Who are the supportive people in your life?

Do they support your decision for Weight Loss Surgery?

What are your expectations and motivations for undergoing weight-loss surgery, aside from weight loss?

Please check one of the following:

☐ Yes, I want this surgery

☐ No, I do not want this surgery at this time

Any other information we should know:

Signature: _____ Date (yyyy/mm/dd): _____