UHN Toronto Western Hospital

Bariatric Surgery Program

Medical Health History Form

This form should only be completed by your PCP (primary care provider) such as a family doctor or nurse practitioner.

Email this form to bariatricclinic@uhn.ca or fax to 416-603-5142

Patient Demographics:

Patient name:______________________________

Date of birth: __________________

Health card number (OHIP): ________________

Version code:_____

Required patient measurements

Height: _______________

Weight: _______________

Neck circumference (in): ________________

Waist circumference (in): ________________

Blood Pressure: _____________

Allergies:

Sleep Apnea Assessment

Please complete a STOP-BANG assessment on your patient to see whether they need a sleep study. Please tally the questions and if your patient scores a minimum 4/8 please send them for a sleep study.

Do you snore loudly?	
Do you often feel tired or fatigued after your sleep?	
Has anyone ever observed you stop breathing in your sleep?	
Do you have or are you being treated for high blood pressure?	
Is BMI greater than 35 kg/m2?	
Age older than 50 years old?	
Neck Circumference Greater Than (17 inches Male) or (16 inches Female)	
Gender: Male?	
STOP-Bang Total Score	

Please send a copy of the following as necessary:

- Most recent sleep study (no later than 3 years)
- A CPAP titration report or any sleep clinic follow up notes
- Cardiac investigations and consults in the last 5 years

Past medical history

Medications

Past surgeries/procedures

Print name (MD/NP) Signature Date