Date: ___________________________

Name: ___________________________

Date of Birth: ___________________

Healthcare #: ____________________

Mail or Fax the forms back to us:
Calgary Adult Bariatric Surgery Clinic, 2nd Floor RRDTC, 1820 Richmond Rd SW, Calgary, AB T2T 5C7
Fax: (403) 476-9626

ADHD screening

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an "X" in the box that best describes how you have felt and conducted yourself over the past 6 months.	**Never**	**Rarely**	**Sometimes**	**Often**	**Very Often**
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Date: ___________________________

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EQ5D

Under each heading, please tick the one box that best describe your health TODAY.

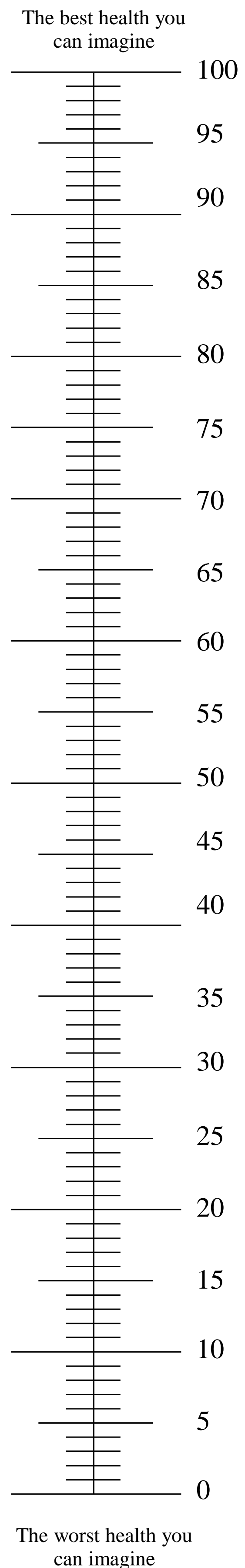
MOBILITY	
I have no problems in walking about	
I have slight problems in walking about	
I have moderate problems in walking about	
I have severe problems in walking about	
I am unable to walk about	
SELF-CARE	
I have no problems washing or dressing myself	
I have slight problems washing or dressing myself	
I have moderate problems washing or dressing myself	
I have severe problems washing or dressing myself	
I am unable to wash or dress myself	
USUAL ACTIVITIES (e.g. work, study, housework, family, or leisure activities)	
I have no problems doing my usual activities	
I have slight problems doing my usual activities	
I have moderate problems doing my usual activities	
have severe problems doing my usual activities	
I am unable to do my usual activities	
PAIN/DISCOMFORT	
I have no pain or discomfort	
I have slight pain or discomfort	
I have moderate pain or discomfort	
I have severe pain or discomfort	
I have extreme pain or discomfort	
ANXIETY/ DEPRESSION	
I am not anxious or depressed	
I am slightly anxious or depressed	
I am moderately anxious or depressed	
I am severely anxious or depressed	
I am extremely anxious or depressed	

December 2020

Name: ___________________________

Alberta Health Services

EQ5D



- We would like to know how good or bad your health is **TODAY**.
- This scale is numbered from 0 to 100
- 100 means the **best** health you can imaging
  0 means the **worst** health you can imagine
- Mark an X on the scale to indicate how your health is TODAY
- Now, please write the number you marked on the scale in the box below.

YOUR HEALTH TODAY =

December 2020

Date: ___________________________

Name: ___________________________

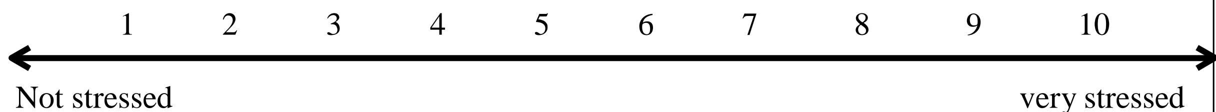
Date of Birth: ___________________

Healthcare #: ___________________

GAD-7 screening for anxiety				
Over the <u>last 2 weeks</u>, how often have you been bothered by the following problems?	**Not at all** **0**	**Several days** **1**	**More than half the days** **2**	**Nearly every day** **3**
1. Feeling Nervous, anxious or on edge				
2. Not being able to stop or control worrying				
3. Worrying too much about different things				
4. Trouble relaxing				
5. Being so restless that it is hard to sit still				
6. Becoming easily annoyed or irritable				
7. Feeling afraid as if something awful might happen				

General Stress

Check the number that best indicates your general level of stress.



List your 3 main stressors

1______________________ 2______________________ 3______________________

Date: ____________________

Name: ____________________

Date of Birth: ________________

Healthcare #: ________________

PHQ-9				
Over the last 2 weeks, how often have you been bothered by the following problems?	**Not at all** **0**	**Several days** **1**	**More than half the days** **2**	**Nearly every day** **3**
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself - or that you are a failure, or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite; being so fidgety or restless that you have been moving around more than usual.				
9. Thoughts that you would be better off dead or of hurting yourself in some way.				

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Alberta Health Services

Date: ______________________

Name: ______________________

Date of Birth: ________________

Healthcare #: ________________

Calgary Adult Bariatric Surgery Clinic

SLEEP

Do you have sleep apnea?	YES ☐	NO ☐
If yes, is it being treated?	YES ☐	NO ☐

STOP Bang Sleep Apnea Questionnaire

Chung F et al Anesthesiology 2008 and BJA 2012

Please answer the following questions to determine if you may be at risk for sleep apnea:

Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)?	YES ☐	NO ☐
Do you often feel TIRED, fatigued, or sleepy during daytime?	YES ☐	NO ☐
Has anyone OBSERVED you stop breathing during your sleep?	YES ☐	NO ☐
Do you have or are you being treated for high blood PRESSURE?	YES	NO
Is your BMI more than 35kg/m2?	YES ☐	NO ☐
Is your AGE over 50 years old?	YES ☐	NO ☐
Is your NECK circumference > 16 inches (40cm)?	YES ☐	NO ☐
Is your GENDER Male?	YES ☐	NO ☐

Please answer as many of these questions as you can. If you do not know an answer, please skip it and discuss it with the Registered Nurse at your appointment.

Date: ____________________________

Name: ___________________________

Date of Birth: ___________________

Healthcare #: ___________________

Gastroesophageal Reflux Disease-Health Related Quality of Life Instrument GERD-HRQL

• **Scale**: No symptoms = **0**; Symptoms noticeable, but not bothersome = **1**; Symptoms noticeable and bothersome, but not every day = **2**; Symptoms bothersome every day = **3**; Symptoms affect daily activities = **4**; Symptoms are incapacitating, unable to do daily activities = **5**

Questions	0	1	2	3	4	5
1. How bad is your heartburn?						
2. Heartburn when lying down?						
3. Heartburn when standing up?						
4. Heartburn after meals?						
5. Does heartburn change your diet?						
6. Does heartburn wake you from sleep?						
7. Do you have difficulty swallowing?						
8. Do you have pain with swallowing?						
9. Do you have bloating or gassy feelings?						
10. If you take medication does this affect your daily life?						

How satisfied are you with your present condition? Satisfied _____Neutral _____Dissatisfied ______

For office coding ___+ ____+ ____+ ____+ ____+____+ ____

= Total Score: ____

Date: ____________________

Alberta Health Services

Name: ____________________

Date of Birth: ____________________

Healthcare #: ____________________

AUDIT

For each question below, check mark the answer that best describes you.

One Standard Drink =

341 ml (12 oz) bottle of 5% alcohol beer, cider or cooler

142 ml (5 oz) glass of 12% wine

43 ml (1.5 oz) shot of 40% hard liquor (vodka, rum, whiskey, gin, etc.)

Questions	0	1	2	3	4
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	**Daily or almost daily**
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	**Daily or almost daily**
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year

_______ _______ _______ _______ _______

Total Score = ____