PATIENT INFORMATION FORM

MR / MRS / MISS / MS / DR SURNAME:_____ **FIRST NAME/S:** _____

DATE OF BIRTH: _____/_____/_____ **SEX:** **MALE / FEMALE**

ADDRESS: _____

_____

HOME PH: _____ **WORK PH:** _____ **MOBILE:** _____

EMAIL ADDRESS: _____

GENERAL PRACTITIONER: _____

MEDICARE NUMBER: _____ **REF. NO (BESIDE YOUR NAME):**_____ **EXPIRY DATE:** _____/_____

PRIVATE HEALTH INSURANCE? **YES / NO** **VETERAN AFFAIRS NUMBER (IF APPLICABLE):** _____

IF YES, FUND NAME: _____ **FUND NUMBER:** _____

COMMONWEALTH CONCESSION CARD? **YES / NO** **CARD NO.** _____ **EXPIRY DATE:** ___/___/____

NEXT OF KIN: _____

RELATIONSHIP: _____ **CONTACT NUMBER:** _____

ARE YOU DIABETIC? **YES / NO** **DO YOU HAVE:** **HEP B?** **YES / NO** **HEP C?** **YES / NO** **HIV?** **YES / NO**

DO YOU TAKE ANY OF THE FOLLOWING? IF YES, PLEASE CIRCLE: **FORXIGA** **XIGDUO** **JARDIANCE** **JARDIAMET**

In December 2000 an amendment act was passed through the Federal parliament relating to the Privacy Act. This amendment came into effect on 21/12/2001.

We require your consent to collect personal information about you. Please read this form carefully, and sign where indicated below.

Queensland Bariatrics, the Wesley Obesity Clinic, Dr Blair Bowden, Dr Jennifer Duncombe and Dr Louise Gore-Jones collect information from you for the primary purpose of providing quality health care. We ask that you provide us with your personal details and full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways:

- Administrative purposes in running our medical practice.
- Billing purposes.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- Emergency situations whereby medical officers/hospitals require access to patient notes for treatment purposes.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management.

I have read the information above and understand the reasons why my information must be collected. I am also aware that Queensland Bariatrics, the Wesley Obesity Clinic, Dr Blair Bowden, Dr Jennifer Duncombe and Dr Louise Gore-Jones have a privacy policy on handling patient information.

I understand that I am not obliged to provide any information requested of me, but my failure to do so might compromise the quality of the health care and treatment of me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.

I consent to be contacted by email, telephone or SMS to confirm upcoming appointments or to send me patient related information.

PATIENTS NAME: _____ **DOB:** _____

SIGNATURE: _____ **DATE:** _____

QUEENSLAND BARIATRICS

NEW PATIENT SURVEY

PATIENT NAME: _____

HOW DID YOU HEAR ABOUT OUR CLINIC? (PLEASE TICK ALL OPTIONS THAT APPLY)

- ☐ GENERAL PRACTITIONER
- ☐ SPECIALIST
- ☐ A FRIEND OR FAMILY MEMBER
- ☐ INFORMATION SEMINAR
- ☐ INFORMATION BROCHURE
- ☐ NEWSPAPER ADVERTISEMENT
- ☐ MAGAZINE ADVERTISEMENT
- ☐ WEBSITE ADVERTISEMENT
- ☐ GASTRIC BANDING WEBSITE
- ☐ OTHER: _____

WHAT ARE YOUR REASONS BEHIND CONSIDERING GOING AHEAD WITH SURGERY?
E.G. HEALTH, QUALITY OF LIFE, CLOTHING NOT FITTING, SOCIETY, JOB

_____

_____

_____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS SURVEY.

SOCIAL PROFILE

Family Structure: Married / Divorced / Single / Partner

Children and their ages: _____

Do you have support persons/friends: Yes / No

Occupation: _____ Fulltime / Part Time / Casual /Unemployed

If unemployed, what is the reason? _____

If unemployed, are you currently looking for work? Yes / No

Has your weight made it difficult to find work? Yes / No

If employed, what level of activity does your job involve? Little (Sedentary) Moderately Active Very Active

WEIGHT HISTORY

		BELOW AVERAGE	AVERAGE	ABOVE AVERAGE	VERY HEAVY
Please indicate your weight at the following times by checking the relevant box	Birth Weight				
	Weight Starting School				
	Weight Beginning High School				
	Weight Finishing High School				
	Weight Commencing Work				
	Weight at Marriage				

Past attempts at weight loss:

	PROGRAMS	FAD DIETS	MEDICATION	MEAL REPLACEMENT
Example	Weight Watchers, Jenny Craig	Atkins, Zone, Low GI South Beach, Dr Phil	Reductil, Duromine Xenical, Medislim	Tony Ferguson, Optifast, Motivation
Tried?				
Duration:				
Weight Lost:				

Details of any other weight loss measures (including surgical): _____

_____

Was there any particular event which lead to significant weight gain, if so what? _____

_____

PERSONAL MEDICAL HISTORY

	YES	NO	DETAILS		YES	NO	DETAILS
Diabetes				Gestational Diabetes			
Asthma				Respiratory Problems			
Arthritis / Joints				Back Pain			
Kidney Disorder				Urinary Disorder			
Neurological Disorder				Psychological Disorder			
Gallstones				Reflux/Heartburn			
Gastric/Duodenal Ulcer				High Blood Pressure			
Hepatitis/Liver Disorder				Heart Disease			
High Cholesterol				Anaemia/Blood Disorder			
Thrombosis/Clotting				Varicose Veins			
Eczema/Skin Disorder				Hayfever/Rhinitis			

Please give details of any major illnesses or problems: _____

_____

_____

_____

FAMILY MEDICAL HISTORY

	PARENT	SIBLING/CHILD	OTHER RELATIVE	NONE	DON'T KNOW
Diabetes					
Heart Disease					
Hypertension					
Gout					
Gallstones					
Obesity					
Sleep Apnoea / Snoring					
Asthma					
Allergies					
Hayfever					
Eczema / Skin Disorder					
High Cholesterol					
Osteoporosis					
Hip Fractures					

SOCIAL HISTORY

Allergies? _____

Alcohol Intake (standard drinks per week): _____

Cigarettes: Yes No If yes, how many per day? _____ For how long? _____years. Ceased? _____

FOR THE LADIES ONLY

Do you have regular periods (26-33 days)? Yes / No

If not, please give details: _____

Do you have problems with excessively heavy periods? Yes / No

If yes, please give details: _____

Have you had difficulty conceiving in the past? Yes / No

Do you currently have problems with infertility? Yes / No

Have you suffered from excess body hair or acne? Yes / No

Have you been told that you have polycystic ovaries? Yes / No

Have you had problems child birth or pregnancy? Yes / No

If so, in what way? _____

Have you had a caesarean section? Yes / No

If so, please give details: _____

SURGICAL HISTORY

Please give details of any past operations: _____

_____

_____

MEDICATIONS

	YES	NO	DETAILS		YES	NO	DETAILS
Psychiatric				Migraine			
Weight Loss				Epilepsy			
Asthma				Hormones (e.g. the pill)			
HRT				Cortisone			

Please list all medications used in the past twelve months

_____

_____

SLEEP HISTORY

How many hours sleep do you get a night? _____hrs How would you consider your quality of sleep? _____

Is there anything that keeps you awake at night? Yes / No

Details: _____

If your sleep is a major problem to you or your partner, would you be prepared to have a sleep study? Yes / No

During the last month, have you had, or have you been told about the following symptoms:

SYMPTOM	NEVER	RARELY	1-2 WEEK	3-4 WEEK	5-7 WEEK	DON'T KNOW
Snorting or gasping						
Loud snoring						
Breathing stops, choking						
Frequent awakenings						
Tossing and turning						
Difficulty falling asleep						
Restless legs						
Falling asleep at work						
Falling asleep driving						
Sleepiness during the day						
Paralysed feelings whilst awake						

How likely are you to **doze off or fall asleep** in the following situations, in contrast to just feeling tired?

SITUATION	NO CHANCE	SLIGHT CHANCE	MODERATE CHANCE	HIGH CHANCE
Sitting and reading				
Watching TV				
Sitting in public (e.g. Movies)				
Passenger in car for 1hr +				
Lying down in the afternoon				
Sitting and talking to someone				
Sitting quietly after lunch				
In the car, stopped for few mins in traffic				

BREATHING HISTORY

Does being at work ever make your chest tight or wheezy? Yes / No

Details: _____

Have you ever had to change jobs as it was affecting your breathing? Yes / No

Details: _____

Have you ever worked in a job, which exposed you to vapours, gas, dust or fumes? Yes / No

Details: _____

Have you ever had an asthma attack? Never Currently In the Past Don't Know

Have you ever been admitted to a hospital due to asthma or breathing problems? Yes / No

If yes, was it in the last 12 months? Yes / No

In the last 12 months, have you visited an emergency room or a doctor urgently due to asthma or breathing problems?

Yes / No Details: _____

Do you usually have a cough? Yes / No Do you get short of breath on exertion? Yes / No

Do you bring up phlegm when coughing? Yes / No Do you short of breath on the flat? Yes / No

Do you get short of breath walking up hills? Yes / No

In the past 12 months…….

Have you had an attack of shortness of breath that came on with no obvious cause? Yes / No

Have you had wheezing on your chest? Yes / No

Have you had wheezing on your chest that came on after you stopped exercise? Yes / No

Have you had a feeling of chest tightness when waking in the morning? Yes / No

What exercise do you do on a regular basis and how often? (e.g. team sports, walking, swimming, gym)

_____

_____

GASTRO-OESOPHAGEAL REFLUX / INDIGESTION HISTORY

Do you have a history of heartburn or indigestion? Yes / No Details: _____

If yes, how often do you have reflux during the day?

Many Times Everyday Most Days Most Weeks Occasionally

Do you suffer from heartburn/indigestion during the night? If so, how often?

Many Times Every Night Most Nights Most Weeks Occasionally

Do you have difficultly swallowing? Yes / No Details: _____

Does food ever get stuck? Yes / No Details: _____

Does food or fluid reflux in your mouth? Yes / No Details: _____

Do you vomit with reflux? Yes / No Details: _____

Do you have recurrent sore throats? Yes / No Details: _____

Do you suffer from a hoarse voice? Yes / No Details: _____

Do you suffer from a cough at night? Yes / No Details: _____

Please list any treatments you use for heartburn, reflux or indigestion:

_____

_____

ANY OTHER RELEVANT INFORMATION?

_____

_____

_____

_____

_____

_____

THIS SECTION WILL BE COMPLETED BY THE NURSE DURING YOUR CONSULTATION

MEDICAL ASSESSMENT

Measurements

Weight:	_____kg's	Height:	_____ cm's
Ideal Weight	_____kg's	BMI:	_____kg/H2
% Excess Weight	_____kg's	Waist:	_____cm's
Hip:	_____cm's	Waist/Hip Ratio	_____
Blood Pressure:	_____mmHg	Sagittal Diameter	_____cm's

Other:

_____

_____

_____

_____