Patient Details – Bariatric Surgery

Personal Details

Title: ____ Surname: _____ Given name: _____

Address: _____

Suburb: _____ Postcode: _ _ _ _

DOB: ___ / ___ / _____

Mobile: _ _ _ _ _ _ _ _ _ _ Home Phone: _ _ _ _ _ _ _ _ _ _

Email: _____ Work Phone: _ _ _ _ _ _ _ _ _ _

Medicare/Health fund

Medicare Number: _ _ _ _ _ _ _ _ _ _ _ Patient Ref No: _ Expiry: _ _ / _ _ _ _

Hospital Fund: _____ Membership Number: _____

Level of Cover: _____ Have you served waiting period: _____

DVA: Status: _____ Number: _____

If this is a Work Cover/TAC Claim please provide details: _____

_____

Next of Kin

Surname: _____ Given Name:_____

Contact number: _____ Relationship: _____

Medical History

Do you have Reflux or Heartburn?	☐ Yes	☐ No
Do you have High Blood Pressure?	☐ Yes	☐ No
Are you a Type 1 Diabetic?	☐ Yes	☐ No
Are you a Type 2 Diabetic?	☐ Yes	☐ No
If yes, are you on... ☐ Medication ☐ Insulin ☐ Both		
Do you have a history of Heart Disease?	☐ Yes	☐ No
Details:		
Do you have any Respiratory / Breathing Problems?	☐ Yes	☐ No
Details:		
Do you have Sleep Apnoea?	☐ Yes	☐ No
If yes, do you use a CPAP machine?	☐ Yes	☐ No
Are you a current smoker?	☐ Yes	☐ No
If yes, how many do you smoke a day?		
Are you a past smoker?	☐ Yes	☐ No
If yes, when did you cease?		
Do you drink alcohol?	☐ Yes	☐ No
If yes, volume: Frequency:		

Name: _____

Do you have a pace maker or internal defibrillator? Details:	☐ Yes	☐ No
Have you had previous weight loss surgery with another surgeon? Details:	☐ Yes	☐ No
Have you had any other previous surgeries? E.g. gallbladder removal. Details:	☐ Yes	☐ No
Do you have any other medical conditions? Details:	☐ Yes	☐ No
Please list all allergies:		
Current height and weight? Height (cm) _____ Weight (kg) _____		

Name: _____

Weight Loss Questionnaire
Please explain why you are considering weight loss surgery:
Please list other methods of weight loss that you have tried (e.g. diet plans, exercise, surgery):

Current Medications

Mr Adam Skidmore
Upper GI, General & Bariatric Surgeon

The medications that you are on may affect the outcome of any upcoming surgery.

Please complete this form so that your medications, including herbal medications, can be assessed. If required, you will be advised of medication you will need to cease prior to surgery. In some cases, an alternative medication will be organized.

If you are on no medications, please write NA.

Name (please print): _____

Signature: _____ **Date:** ___/___/____

MEDICATION NAME	DOSAGE

2022-1