JordaanSurgical
P: 07 5556 8888 F: 07 5527 8226
E: info@jordaansurgical.com.au
SURGICAL WEIGHT LOSS CENTRE

NAME: DR | MR | MRS | MS | MISS *(please circle)*

SURNAME: _____ FIRST NAME: _____

KNOWN AS: _____

DATE OF BIRTH: _____ MARITAL STATUS: _____

ADDRESS: _____

TELEPHONE: (H): _____ (B): _____ (M): _____

EMAIL: _____

NEXT OF KIN: _____ RELATIONSHIP: _____

THEIR CONTACT NO.: _____

PRIVATE HEALTH FUND: (NAME) _____ (NUMBER): _____

LEVEL OF COVER (IF KNOWN) _____

HAS THIS LEVEL OF COVER CHANGED WITHIN THE LAST 12 MONTHS? YES NO

MEDICARE NUMBER: _____ REF NO.: _____ EXP: _____

VET AFFAIRS NO.: _____

WHO IS YOUR REFERRING DOCTOR? _____

WHO IS YOUR USUAL GP? _____

WHO ARE THE SPECIALISTS INVOLVED IN YOUR HEALTH CARE?

_____

How did you hear about us? _____

ACCOUNT STRUCTURE:
I understand that I am responsible for the payment of my accounts with Dr Jacobus F Jordaan. I understand that Dr Jordaan charges AMA rates. If I have an operation, I am aware that there may be out of pocket expenses involved after claim has been made through Medicare and my Health Fund. *PLEASE NOTE: IF YOU REQUIRE SURGERY, THERE MAY BE OUT OF POCKET EXPENSES FOR PATHOLOGY AND RADIOLOGY WHILE IN HOSPITAL.*

DISCLOSURE CONSENT:
I consent to the disclosure to medical/specialist practitioners, allied health practitioners and institutions who may require information about my medical history but only to the extent necessary to assess/treat the particular condition that I have consulted the medical/specialist practitioner about. In understand an identification photograph will be taken which forms part my medical record. I understand I can retract this consent at any time upon written advice to my medical/specialist practitioner. I agree to the above Account Structure and Disclosure Consent.

SIGNED: _____ **DATE:** _____

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INITIAL APPOINTMENT QUESTIONNAIRE

Please take your time to complete this questionnaire. The information you provide in your answers is important - it will help us tailor your treatment to your unique circumstances.

HEIGHT: _____ **WEIGHT:** _____

MEDICATIONS

What medications are you currently taking? (Includes pain killers or occasional medication)

Medication	Dose	Frequency	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you recently had any medication changes? _____

Do you take any of the following medications? PLEASE CIRCLE ANY YOU DO TAKE

Aspirin Clopidogrel Plavix Iscover Warfarin Xarelto

Cortisone Steroids Anti-inflammatories

Fish Oil Krill Oil Garlic tablets Ginko supplements

Do you have any allergies? YES NO

If yes, please list the allergen and your reaction:

_____

INSURANCE INFORMATION

Do you have private health insurance? YES NO

Does your private health fund cover bariatric surgery? UNSURE YES NO

Do you intend to access your Superannuation for payment of surgery? YES NO

If yes, will you be applying for total surgery amount of for the GAP? YES NO

TELL US ABOUT YOUR WEIGHT LOSS HISTORY

Since what age have you been overweight?_____

What is the most you have weighed in the last 10 years? _____

What is the least you have weighed in the last 10 years? _____

Please list the weight loss programs you have tried in the past:

Year	*Program type*	*Weight loss (kg)*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever taken a weight loss medications? YES NO

Medication name _____ For how long? _____

Weight loss (kg): _____

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Have you had any weight loss operations in the past? YES NO

Operation _____

Surgeon _____

Date of Surgery _____ Weight loss (kg): _____

DO YOU HAVE ANY OF THE FOLLOWING WEIGHT-RELATED MEDICAL CONDITIONS?

Type 2 Diabetes: YES NO

When were you diagnosed? _____

Is this well managed/controlled? YES NO

Do you see a specialist regarding this? _____

How regularly are your bloods checked? _____

Hypertension: YES NO

When were you diagnosed? _____

Is this controlled/managed? _____

How often is it checked? _____

Do you see a renal physician, specialist or GP in regards to this? _____

Obstructive Sleep Apnea: YES NO

Have you ever undergone a sleep study? YES NO

Do you have a CPAP mask? YES NO

If yes, how often do you use it? _____

Who is your respiratory physician? _____

Osteo-arthritis: YES NO

If yes, which joints are most affected? _____

Chronic back pain: YES NO

Respiratory conditions:

COPD YES NO

Asthma YES NO

Chronic CO2 Retention (hypoventilation syndrome) YES NO

Do you take inhalers/ Steroids YES NO

Do you ever get shortness of breath? YES NO

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TELL US ABOUT YOUR DIGESTIVE HEALTH

Do you have acid-reflux or heartburn? YES NO

If yes, do you need to take anti-reflux medications? YES NO

Reflux medications and frequency (if not already listed):

_____

Do you experience any reflux symptoms even after taking this medication? YES NO

If yes, how often? _____

How long can you go without medication before your symptoms recur?_____

Do you take any medication on a "need to" basis for reflux or indigestion? YES NO

Have you ever undergone investigations for abdominal pain? YES NO

Investigation *Date* *Outcome*

_____

_____

Do you ever experience abdominal pain or cramping, especially after meals? YES NO

If yes, how often? _____

When did you last experience it? _____

Have you ever been diagnosed with gallstones? YES NO

Has your gallbladder been removed? YES NO

How would you describe your bowel habits?

REGULAR PRONE TO CONSTIPATION PRONE TO DIARRHEA ERRATIC

TELL US ABOUT YOUR HEART HEALTH

Have you ever been diagnosed with a cardiac condition? YES NO

Have you ever seen a cardiologist? YES NO

If yes, name of cardiologist: _____

Date of first visit: _____

Date of last visit: _____

Have you ever had a coronary angiogram? YES NO

Do you have a coronary stent/s? YES NO

Have you ever had a coronary angiogram? YES NO

Do you have atrial fibrillation or any form of palpitations? YES NO

Do you have high cholesterol? YES NO

Do you have a family history of heart disease? YES NO

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TELL US ABOUT YOUR SURGICAL HISTORY

Have you had any operations in the past, apart from weight-loss surgery? YES NO

Operation *Date*

_____ _____

_____ _____

_____ _____

TELL US ABOUT YOUR MEDICAL HISTORY

Have you had a blood clot, e.g., deep vein thrombosis (DVT) or pulmonary embolus? YES NO

If yes, when and where? _____

What treatment have you/are you undergoing for this? (anticoagulants etc.)

_____

Was the cause of this identified? _____

Do you have a family history of blood clotting or bleeding disorders? YES NO

Have you ever had excessive bleeding during or after surgery in the past? YES NO

If yes, when and where? _____

Do you have any other medical conditions not already outlined in this questionnaire? YES NO

If yes, please list: _____

Do you see any other specialists not already listed? YES NO

If so, who and why?_____

Do you take any supplements? YES NO

If yes, please list and explain what for:

_____

_____

TELL US ABOUT YOUR SMOKING & ALCOHOL HISTORY

Do you currently smoke? YES NO

Have you smoked in the past? YES NO

If yes, how old were you when you started and stopped _____

How many do/did you smoke per day? _____

Have you ever used recreational drugs? YES NO

How many alcoholic drinks to you have a week? _____

Are you taking any other medications not already outlined in this questionnaire? YES NO

If yes, please list and explain why you take them:

_____

_____

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TELL US ABOUT YOUR PSYCHOLOGICAL HISTORY

Do you currently see a psychologist? YES NO

Have you seen a psychologist in the past? YES NO

Do you currently see a psychiatrist? YES NO

Have you seen a psychiatrist in the past? YES NO

Have you ever been admitted to a mental health facility? YES NO

Do you take any medication for mental health conditions? If yes, please list:

_____

Do you have any home help? YES NO

Can you drive? YES NO

Do you have limitations in daily life? YES NO

If so, what type? _____

TELL US ABOUT YOU

What do you do for a living? _____

What do you enjoy doing? _____

Do you have a significant other? _____

Do they support your decision to undertake bariatric surgery? YES NO