Personal Details	
Surname:	First Name:
Mr Mrs Ms Miss Other	D.O.B:
Address:	
Home Phone:	Mobile:
Work Phone:	Email:
	Can we use this email to contact you regarding your treatment?
	Yes No
Occupation:	
Number and age of children (if applicable):	
Country of Birth:	Are you an Australian Resident? Yes No
Other Contact (Spouce, Partner, Parent, Other Relative, Friend)	
Name:	Relationship to you:
Address:	
Home Phone:	Mobile:
Work Phone:	Email:
Healthcare Card Details	
Medicare Number:	Ref: Exp Date
Health Fund (if applicable):	Membership Number:
Pension:	Exp Date:
Veteran Affairs Number:	DVA Card Colour:
GP Details	
Name:	Phone:
Address:	
Email:	Fax:
Other Doctors/Specialists involved in your care	
Name: Speciality:	Address:
Referral Details	
How did you hear about our practice?	
Name of Referring Doctor:	
Reason for Referral:	
Have you read and consent to the practice Privacy Policy?	
Name:	
Signature:	Date:

Medical History

Personal History (Have you ever suffered from any of the following health problems?)

Illness	**Yes**	**Details: eg approximate year of diagnosis**
Type 2 Diabetes	☐	
Pre-diabetes or Insulin resistance	☐	
Asthma	☐	
Respiratory/Breathing Problems	☐	
Sleep Apnoea	☐	Are you using a CPAP/ BIPAP or similar device?
Stroke or TIA (mini-stroke)	☐	
Anxiety	☐	
Depression	☐	
Other mental health illness	☐	
Gallstones	☐	
Heartburn/ Reflux	☐	
Fatty liver	☐	
Hepatitis/Liver Disease	☐	
High Blood Pressure/Hypertension	☐	
High Cholesterol	☐	
Heart Failure	☐	
Heart Disease/ Angina	☐	
Clotting Disorder/Blood Clot	☐	
PCOS	☐	
Low Iron/ Iron deficiency anemia	☐	
Cancer	☐	
Other: (Please specify)		

Other

Have you ever smoked?	Yes	No	If Yes, how many?
How long?			Have you/when did you stop?
How many standard alcoholic drinks do you have per week?			

Surgical History (Please give details of any past operations, especially abdominal)

Procedure:	Date:

Family History (Are there any illneses in your immediate family eg. Parents?)

(i.e diabetes, heart disease, stroke, high cholesterol, high blood pressure, cancer, blood clots etc? Please list)

Medications (Please state all medications that you are on)

Medication:	Reason for taking:

Weight Loss History

General Weight Loss Questions

How long have you been living with excess weight?	Years
How many years have you been seriously trying to lose weight?	Years
What is the maximum weight lost by any method?	kgs
Approximately what was your lightest weight since 18yo?	kgs
Approximately in what year were you at your lightest weight?	
Approximately what was your heaviest ever weight?	kgs
Approximately in what year were you at your heaviest weight?	kgs

Which of the following have you tried?

Dieting	**Yes**	**Weight loss medication**	
Jenny Craig	☐	Duramine	☐
Weight Watchers	☐	Xenical	☐
Sure Slim	☐	Saxenda/other injectable medication	☐
Atkins	☐	Contrave	☐
Liquid Diets eg Optifast/ Tony Ferguson etc	☐	Other	☐
Other diet:			

Previous Bariatric Metabolic Surgery

Procedure:	Approximate year:

Reflect on your eating habits… Do you		**Do you regularly drink any of these liquid calories?**	
Consider yourself a "foodie" i.e. love food	☐	Carbonated/fizzy/soft drinks	☐
Eat large portions/ go for a second helping?	☐	Fruit juice	☐
Feel that your stomach never feels full?	☐	Milk-based drinks eg lattes, milkshakes etc	☐
Eat when you're not hungry eg bored, etc?	☐	Energy drinks eg Vs, Redbull etc	☐
Experience "cravings" for certain foods/drinks?	☐	Bubble tea/ other sweetened drinks	☐

Previous Bariatric Metabolic Surgery

Procedure:	Approximate year:

Exercise

Are you doing any regular exercise at the present time?	Yes	No
If yes, what type?		
How many hours per week?		