OClinic

OVERCOME OBESITY

OFFICE USE ONLY GENIE ID:				
Date	Weight (kg)	Height (cms)	BMI	Excess
Target weight	Max weight	Insurance	Super release	Procedure
Hospital	ICU	Alert		

NEW PATIENT INFORMATION SHEET

All fees are requested at the time of consultation unless paid prior to consultation.

Title:_______First Name:________________________Surname:____________________________
(As it appears on your Medicare and Health Insurance Card)

Prefer to be called: _____________________________Marital Status:________________________

Address:____

Suburb:______________________________ State:_____________ Post Code:______________

Date of Birth:__________________Age: ____________ Sex: Male / Female (Please circle)

Home Phone:______________Work Phone:_________________Mobile:_____________________

Email address: ____

Medicare No:__________________________Reference No. ______ Card Expiry:______________

Indigenous status: Aboriginal origin Y / N TSI origin Y / N

Are you registered for Ehealth? Y / N If yes what is your number?_____________________

Do you have private health insurance? Y / N

Private Health Fund:___________________Membership No.______________________________

Do you intend to release your superannuation? Y / N

Dept Veteran Affairs No:______________________Occupation:____________________________

Referring Dr:__________________________Practice Name and Address: ____________________

____Phone:____________________
Correspondence will be sent to your referring Doctor. Do you agree to this? Y / N

NOK/Emergency Contact:_____________________________ NOK Phone:____________________

Relationship to you____

PERSONAL HISTORY

MEDICAL HISTORY

Weight related Medical Conditions: Do you have any of the following conditions?

High blood pressure Y / N	High cholesterol Y / N
Angina (cardiac chest pain) Y / N	Infertility Y / N
Weight bearing joint pain Y / N Which joints? ______________________________	Polycystic Ovary Syndrome Y / N Do you have insulin resistance Y / N
Fatty Liver Y / N	
Diabetes type 2 Y / N If yes, how long have you had Diabetes? What treatment is used to control your Diabetes? Tablet controlled Y / N Diet controlled Y / N Is insulin required Y / N	
Gallstones Y / N unsure	Chronic heartburn or reflux Y / N
Have you had your gallbladder removed? Y / N	
Do you have a hiatus hernia? Y / N Unsure	
Depression Y / N Have you noticed improvement when you lose weight? Y / N	
Do you have sleep apnoea? Y / N Unsure Has this been confirmed with a sleep study? Y / N Do you use CPAP? Y / N	

Weight loss history

1) How many years have you been struggling with your weight? ______________________________

2) What is your reason/motivation to lose weight? ______________________________

3) How do you feel weight loss surgery can help you? ______________________________

5) What is the most weight (in kg's) you have ever lost? ______________________________

6) What is the heaviest you have ever been? ______________________________

What have you tried in the past to lose weight? (please circle)

Weight Watchers	Tony Ferguson	Lemon detox	Atkins Diet
Pritiken diet	Optifast	Dietitian	Hypnotherapy
Acupuncture	Counseling	Gym membership	Personal trainer
CSIRO diet	Isowhey	Own personal diet	Jenny Craig
Light 'n' easy	Sureslim	Starvation diet	Duromine
Reductil	Xenical	Other	

Reasons for eating (please circle)

Stress
Comfort
Boredom
Binge
Hunger

Are you allergic or intolerant to particular foods? Y / N

If yes please list____

Physical Activity

Do you exercise Y / N

What type of exercise?____

Amount of exercise per day/ week? ____

How does your weight affect your quality of life?

***Please circle - (not at all) 2 (mildly) 3 (moderately) 4 (significantly) 5 (excessively)**

Sleep	1	2	3	4	5
Energy	1	2	3	4	5
Perspiration	1	2	3	4	5
Self Esteem	1	2	3	4	5
Confidence	1	2	3	4	5
Relationships	1	2	3	4	5
Occupational limitations	1	2	3	4	5
Urinary Incontinence	1	2	3	4	5
Avoid being photographed	1	2	3	4	5
Avoid social events	1	2	3	4	5
Avoid swimming in public	1	2	3	4	5

FAMILY HISTORY (Blood relatives)

Do you have a family history of any of the following?

Obesity	☐	Which family member/s?
Diabetes	☐	
Heart Disease	☐	
Stroke	☐	
Cancer - Which type?	☐	

Past Abdominal Surgery (Please indicate if done laparoscopically or open)

Gallbladder removal?	Y / N
Removal of appendix?	Y / N
Colon Surgery?	Y / N

Any other medical problems?

Current Medications – Please list below	
Name of drug	
1.	2.
3.	4.
5.	6.
Current Nutritional supplements	

Allergies	1.	2.
3.	4.	5.

Do you smoke? Y / N

Have you attended an information seminar? Y / N

If yes where? OClinic Other

Do you have a friend or relative that has had weight loss surgery? Y / N

If yes which type? Gastric Lapband Sleeve gastrectomy Other: ____________________

How have you gone about researching weight loss surgery?

TV Newspaper/ Magazines talking to someone who has had surgery

Internet Which site/s?____________________

How long have you been seriously thinking about weight loss surgery?____________________

INITIAL DIET ASSESSMENT

Which best describes your **eating pattern**?

Three meals a day
Three meals, plus snacks
Often skipping meals/no pattern
Grazing throughout the day

In a typical 7-day week, for **breakfast** how many times would you?

Prepare at home____ Eat out/ buy____ Not eat____

Describe your common **breakfast** meals?

E.g. ½ cup natural muesli + ½ cup full fat milk + banana + slice white toast + butter

-
-

Where do you typically eat **breakfast** (e.g. at the table, in front of TV/computer, in car)?

-

In a typical 7-day week, for **lunch** how many times would you?

Prepare at home____ Eat out/ buy____ Not eat____

Describe your common **lunch** meals?

E.g. 2x wholegrain sandwiches with ¼ avocado, tuna + lettuce + low fat yoghurt

-
-

Where do you typically eat **lunch** (e.g. at a table, in front of TV/computer, in car)?

-

In a typical 7-day week, for **dinner** how many times would you?

Prepare at home____ Eat out/ buy____ Not eat____

Describe your common **dinner** meals?

E.g. 200g steak + ½ plate of oven fries + small salad + dressing

-
-

Where do you typically eat **dinner** (e.g. at a table, in front of TV/computer, in car)?

-

If you **snack/graze,** what do you snack on?

E.g. nuts, fruit, chocolate, chips, crackers and cheese, sweet biscuits

-

How often do you eat **potato chips or savory/salty snacks**?

Once a week or less ☐ 2-3 times/ week ☐ 4-6 times/ week ☐ Daily ☐

How often do you eat **chocolate or lollies snacks**?

Once a week or less ☐ 2-3 times/ week ☐ 4-6 times/ week ☐ Daily ☐

How often do you eat **cake, sweet biscuits, muffins or pastries**?

Once a week or less ☐ 2-3 times/ week ☐ 4-6 times/ week ☐ Daily ☐

How often do you eat **fast foods** (e.g. McDonalds, KFC, Hungry Jacks)?

Once a week or less ☐ 2-3 times/ week ☐ 4-6 times/ week ☐ Daily ☐

How many **cups** of the following drinks would you **drink in a day**?

Water	_____	Juice/cordial	_____
Tea/herbal tea	_____	Coffee	_____
Diet cordial	_____	Milk	_____

Diet soft drink ____ Soft drink/ energy drink ____

PSYCHOLOGICAL REVIEW

1. Have you seen (or are currently seeing) a psychiatrist or psychologist? Y / N
2. Have you taken any psychological medication? Y / N
3. Please briefly describe your current work situation: what you do?
   How happy are you in your work? Any career development plans?
   Have you ever had trouble at work or had an extended period of unemployment?
   ____
   ____

4. Please briefly describe your current family/support structure: e.g. single; in relationship; doing well, having troubles; any other marriages or long term commitments; any children; grandchildren etc.
   ____
   ____

5. Have you ever been in trouble with the law? Y / N
6. Alcohol and other drugs: Please let us know any current alcohol (and recreational drugs) usage as well as any past patterns.
   ____
   ____

7. When you think about your over-eating is it mainly driven by hunger feelings or psychological things such as strong emotions, tiredness, general dissatisfaction with life?
   ____
   ____

8. When you think of your weight journey from a psychological point of view, are there any situations, emotions or cognitions (how you think about life) that have made your weight journey a difficult one?______________________________
   ____

9. Have you ever suffered an eating disorder? Y / N
10. Do you consider that you have binge eating episodes? Y / N
11. Is there a "secret" pattern to your eating that you tend to hide from others? Y / N

12. When you look at your body, list the typical words (5 or 6 adjectives) that you think of when describing it to yourself:
    ______________ ______________
    ______________ ______________
    ______________ ______________

13. If you were thinking how the psychologists could help you in your weight loss journey, what practical help (in changing behaviours) do you ask for?
    ____

14. Would you like us to provide you with some detailed psychology weight loss questionnaires that you can fill out in preparation for your psychological intake assessment? Y / N

Alcohol Screen (AUDIT)

Light Beer 425ml 2.9% Alcohol	Full Strength Beer 285ml 4.9% Alcohol	Wine 100ml 12% Alcohol	Fortified Wine 60ml 20% Alcohol	Spirits 30ml 40% Alcohol	Full Strength Can or Stubbie 375ml 4.9% Alcohol

The guide above contains examples of ***one standard drink****.*

A full strength can or stubbie contains ***one and a half standard drinks****.*

Introduction

Because alcohol use can affect health and interfere with certain medications and treatments, it is important that we ask you some questions about your use of alcohol. Your answers will remain confidential, so please be as accurate as possible. Try to answer the questions in terms of **'standard drinks'**. Please ask for clarification if required.

AUDIT Questions Please tick the response that best fits your drinking.

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

Supplementary Questions	*No*	*Probably Not*	*Unsure*	*Possibly*	*Definitely*
Do you think you presently have a problem with drinking?	☐	☐	☐	☐	☐
	Very easy	*Fairly easy*	*Neither difficult nor easy*	*Fairly difficult*	*Very difficult*
In the next 3 months, how difficult would you find it to cut down or stop drinking?	☐	☐	☐	☐	☐

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DASS21

Name: *Date:*

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

PRIVACY CONSENT

The Privacy Act 1988, as amended by The Privacy Amendment (Privacy Sector) Act 2000, requires medical practitioners to obtain consent from their patients to collect, use and disclose patient's personal information. Please read this information carefully and sign where indicated below.

We require you to provide us with your personal details and a full medical history so that you can be properly assessed and treated. The information supplied will be used in the following ways:

Administrative and billing purposes in running the medical practice, including treating doctors, specialists and physiotherapists 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.

Both our practice staff and specialists may participate in the collection of this information.

In emergency situations we may need to collect personal information from relatives or other sources where we are unable to obtain your prior express consent.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.

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 that I will be given an explanation in these circumstances. *(It is likely that you will be asked to contribute to the cost of providing this information)*

I understand that if my information is to be used for any purpose other than set out above, my further consent will be obtained.

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

Signed: ____

Print Name: ____

Date: ____

CLINICAL USE ONLY	
Discussed risks, benefits & alternatives in relation to:	**LAGB** ☐ **LSG** ☐ **Other**
Consent:	**Financial** ☐ **Clinical** ☐
Optifast:	**2 weeks** ☐ **Other** ☐ **Reason:**______________________
Referred to:	**Dietician** ☐ **Psychologist** ☐
Surgery scheduled for: **Date:** ______________________	**SAN** ☐ **Mater** ☐ **Concord** ☐