# QUESTIONNAIRE

Please note, if you have received this form prior to your appointment and require assistance in completing this entire form, please contact the office in advance to allow additional time for your appointment.
Please complete in black ink and in block letters.

**Mr** **Mrs** **Miss** **Ms** *(please tick)* Date:_______________

Surname:____________________ First Name:______________________ Middle Name:________________

Date of Birth:________________________ Age:_______________________________________________

Street Address: _______________________________________________Post Code_________________

Mailing Address: ________________________________________________________________________

Phone (Home):___________________(Work):_____________________(Mobile):___________________

**As a service to our clients we will SMS or phone you prior to your appointment to remind and confirm. Please tick the box to authorise our staff to speak to your spouse / partner.*

Email: (*to discuss your care*)_________________________________________________________________

Medicare No:_____________________________ Ref #_____ Exp______

Aged Pension Card #_______________________Exp _______________

Dept Veterans' Affairs No:__________________ Exp_______________

Health Fund: _____________________________ Health Fund #_______ Extras Cover Hospital Cover

Referral Doctor/Source: _______________________________Regular GP__________________________

Marital Status: ___________________Do you have children? Yes No If yes, ages?__________

Next of Kin:_________________________Relationship:_________________Phone:_________________

Workplace: ________________________________ Occupation:___________________________________

Spouse's name: __________________________________________________________________________

Do you smoke? Yes No Do you drink? Yes No If yes, how often and how much____________

Medications: _____________________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

Medication Allergies**:** _______________________________________________________________________

Food Allergies/Intolerance**:**_________________________________________________________________

Which surgery are you coming to discuss**?** ___________________________________________________

## MEDICAL HISTORY

- Are you a diabetic Yes No
  - Type I or Type II ________
  - If Type II how long have you had it _______ What treatment is used Tablet / Diet / Insulin
- Are you on medication for blood pressure Yes No
- Have you ever had or do you get Angina Yes No
- Do you suffer from weight bearing joint pain Yes No
  - If so, what joints ____________________________
- Do you suffer from arthritis Yes No
  - Have you had a joint injury Yes No
  - Spinal problems Yes No
- Do you have high cholesterol Yes No
- Infertility Yes No
- Polycystic Ovary Syndrome Yes No
- Fatty Liver Yes No Not Known
  - Liver Disease Yes No
- Gallstones Yes No Not Known
- Thyroid problems Yes No
- Asthma Yes No
- Chronic heartburn or reflux Yes No
- Do you have a hiatus hernia Yes No Not Known
- Do you suffer from depression Yes No
  - Have you noticed improvement when you lose weight Yes No
- Do you have sleep apnoea Yes No
  - Confirmed with a sleep study Yes No Do you use a CPAP Yes No

**Other Medical History** ____________________________________________________________________________

## FAMILY HISTORY

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

| | | | | |
|---|---|---|---|---|
| Obesity | Yes | No | Which family member | ____________________________ |
| Heart Disease | Yes | No | Which family member | ____________________________ |
| Stroke | Yes | No | Which family member | ____________________________ |
| Cancer | Yes | No | Which family member | ____________________________ |
| | | | Which type | ____________________________ |
| Asthma | Yes | No | Which family member | ____________________________ |

## SURGERY HISTORY

| | | | |
|---|---|---|---|
| Gallbladder removal | Yes | No | Open or laparoscopically ______________________ |
| Appendix removal | Yes | No | Open or laparoscopically ______________________ |
| Colon surgery | Yes | No | Open or laparoscopically ______________________ |
| Cancer surgery | Yes | No | What type ________________________________ |
| Other surgery | Yes | No | What type ________________________________ |

## WEIGHT HISTORY

How many years have you been struggling with your weight ______________________

What is the heaviest you have ever been ______________________

What is the lowest weight you have been as an adult ______________________

What is the most weight (in kilograms) you have ever lost ______________________

How long have you been seriously considering weight loss surgery ______________________

How do you feel weight loss surgery can help you ______________________

What is your reason / motivation to lose weight ______________________

## DIET/EXERCISE HISTORY *please circle what you have tried in the past to lose weight*

Weight Watchers / Tony Ferguson / Lemon Detox / Atkins Diet / Pritiken Diet / Optifast / Low Carb Diet / Shake Diet / Detox / Delivered Meals / Own personal diet / Jenny Craig / Lite 'n' Easy / Sureslim / Starvation Diet / Smaller portions / Medication / Dietitian / Hypnotherapy / Acupuncture / Counseling / Gym / other______________________________________________________________________

## WEIGHT LOSS GOALS

In the past 12 months, has your weight been increasing / stable / decreasing____________________

What weight would you like to achieve ____________________kg

When did you last weigh this amount ____________________

How long did you maintain this weight ____________ months/years

Was this weight achieved after a weight loss effort Yes No

How much weight do you expect to lose in our program after:

6months_______kg 12 months________kg 24 months________kg

How confident are you that you will be able to significantly change your eating & exercise habits?

Pick a number from 1-10 (In which 1= not at all / 10 = extremely confident)______________________

## OTHER USEFUL INFORMATION

Have you attended a surgical weight loss seminar? Yes No

If so, where? ______________________

Have you researched weight loss surgery? Yes No

If so, where? Internet Newspaper TV Magazine Website Other ____________

Which website?________________________________________________________________

Do you ever feel out of control with food? ______________________________________________

How do you feel weight loss surgery can help you? ____________________________________

Do you cook for yourself/family? __________________________________________________

# DIETARY QUESTIONNAIRE

Please outline your usual day's intake, with alternatives. E.g. breakfast: 1 large bowl of cornflakes + trim milk + 1 tsp sugar + 1 slice wholemeal toast + thin spread of butter + jam OR 2 fried eggs + 3 rashers bacon + 2 slices of toast with butter on weekends. Please record as much detail as possible and write clearly.

| Breakfast | |
|---|---|
| Morning Tea | |
| Lunch | |
| Afternoon Tea | |
| Dinner | |
| Supper | |
| Snacks | |

| How many pieces of fruit do you usually have in a day? |
|---|
| How many glasses of fruit juice do you have a day? |
| How many days per week do you eat vegetables or salad? |
| Can you estimate your serving size of meat in grams or ounces? |
| How often do you eat fish? |
| How much milk would you consume in a day? |
| What type of milk do you use? |
| How often do you eat yogurt? |
| How often do you eat cheese? |
| Do you use butter or margarine? |
| How often do you eat cakes or sweet biscuits? |
| How often do you eat chocolates or lollies? |
| How often do you eat nuts? |
| How many cups of tea or coffee do you drink per day? |
| How many glasses of soft drink or cordial do you drink per day? |
| How many glasses of water would you drink each day? |
| Please list any vitamin supplements you currently take: |
| |
| |

## EXERCISE

| Type of Exercise | Frequency | Time Spent |
|---|---|---|
| | | |
| | | |
| | | |

## 3 DAY FOOD & EXERCISE DIARY

You may find it useful to record your actual intake over 3 days prior to your consultation with the dietitian. Make note of any symptoms you wish to discuss related to food e.g. bowel symptoms, energy levels, headaches. This approach aims to pick up on items you may not think of when answering dietary history questions.

| Meal | Date: | Date: | Date: |
| --- | --- | --- | --- |
| Breakfast | | | |
| Morning Tea | | | |
| Lunch | | | |
| Afternoon Tea | | | |
| Dinner | | | |
| Supper | | | |
| Comments | | | |
| Exercise | | | |

## YOUR PRIVACY

Your privacy is important and handled professionally. In order to provide you with the highest standard of medical care, this practice is required to collect personal information from you. This information covers basic details such as your name, address and telephone number, but it is also necessary to obtain details regarding your general health, past medical and surgical events and social circumstance. There are safeguards to protect this information and all staff are trained to respect your privacy at all times. Information and feedback may be shared with your bariatric team with your permission.

## CANCELLATION POLICY

24 hours notice is required for all consultations.

## CLIENT AGREEMENT

I have read and understand the information provided to me regarding my privacy and give permission for open discussion about my case between my referral source and my bariatric team. In addition, I grant permission to discuss my health with other health professionals/family members in relation to my care:______________________________________________________________

I acknowledge the cancellation policy and privacy statement.

Signed: ______________________________________________________________

Print Name:___________________________________________________________

Email Address:_________________________________________________________

Date:_________________________________________________________________

**Please tick if you would like us to email you when we have an event or a new product that may be of interest to you.**

**Please tick if you have seen the videos on the YouTube link provided by Dr Candice Silverman's rooms.**