Patient Assessment Form

PATIENT INFORMATION

Preferred Title:….. First Name: ………………………… Surname: ………………………………. Gender: …………

Date of Birth: …………………………. Nationality: ………………………………. Passport No.: ………………………….

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Widower

Blood Group: ……………………….. Weight (kg): ………………… Height (cm): ………………… BMI: ……………..

Telephone No.: ………………………………………………. E-Mail Address: ……………………………………………….

Address: ……………………………. Suburb: ………………………………….. City: ……………………………….…

State: ………………………………. Postcode: ………………………………. Country: ……………………………..

Person to notify in case of emergency:

Full Name: …………………………………………………. Relationship: ……………………………….…

E-Mail Address: …………………………………………………. Telephone No.: ……………………………….…

CURRENT HEALTH CONDITION

Underlying Conditions

☐ Cardiovascular disease	☐ Heart Disease	☐ Hypertension	☐ Hypotension
☐ Asthma	☐ Diabetes	☐ Hyperthyroidism	☐ Hypothyroidism
☐ HIV	☐ Hepatitis B	☐ Deep vein thrombosis	☐ Cancer
☐ Adrenal insufficiency	☐ Multiple sclerosis	☐ Keloid scarring	☐ None

Please specify your condition(s): ……………………………………………………………………………………….

Other diseases not mentioned: ……………………………………………………………………………………….

CURRENT MEDICATIONS AND SUPPLEMENTS

☐ NSAIDs Examples:Ibuprofen, I-Profen, Nurofen Brufen, Advil, diclofenac, Voltaren, naproxen ketoprofen	☐ Aspirin	☐ Steroids	☐ Anti-Anxiety
☐ Coumadin/Warfarin, Heparin	☐ Accutane	☐ Fish Oil	☐ Vitamin E
☐ Diet Pills	☐ Sleeping Tablet	☐ None	

Others, please specify: ……………………………………………………………………………………………

If you are taking any medication: How often? (dose per day):

…………………………………………………………………………………

When was the last time you took it?: ……………………………………………………………...

ALLERGIES

Drug Allergy: ☐ Yes ☐ No If yes, please specify: …………………………………………………….

Food Allergy: ☐ Yes ☐ No If yes, please specify: …………………………………………………….

*** SEE OVER PAGE FOR FURTHER DETAILS

MEDICATIONS/PERSONAL MEDICAL HISTORY

Do you take medication for the following:

☐ Medication for psychiatric disorder	☐ Migraine medication	☐ Medications to assist weight loss	☐ Drugs for epilepsy
☐ Asthma	☐ Diabetes	☐ Hormones	☐ Cortisone
☐ Nervous disorder	☐ Neurological	☐ Kidney/urinary disorder	☐ Respiratory
☐ Back pain	☐ Gall Stones	☐ Keloid scarring	☐ Arthritis
☐ Bleeding Problem	☐ None		

Please specify your condition(s) and names of medication:

…………………………………………………………………………………………………..

Other diseases not mentioned: ……………………………………………………………………………………………

PAST SURGICAL HISTORY

Have you had any surgery before? ☐ Yes ☐ No

If yes, please specify:
1) …………………………………………………… Year: ………………
2) …………………………………………………… Year: ………………
3) …………………………………………………… Year: ………………
4) …………………………………………………… Year: ………………

Have you had anesthesia side effects? ☐ Yes ☐ No

If yes, please specify: …………………………………………………………………………………

Do you suffer from:

☐ Reflux/heartburn	☐ Gastric/duodenal ulcer	☐ High blood pressure	☐ Heart disease
☐ High Cholesterol	☐ Anemia/bleeding disorder	☐ Varicose veins/leg swelling	☐ Hypothyroidism
☐ Epilepsy	☐ Hepatitis	☐ Deep vein thrombosis	☐ Diabetes
☐ Adrenal insufficiency	☐ Hayfever/Rhinitis	☐ Keloid scarring	☐ Skin Infection/Eczema
☐ Migraine	☐ None		

Please specify your condition(s) and the medication:

…………………………………………………………………………………………………..

Other diseases not mentioned: ……………………………………………………………………………………………

PSYCHOLOGICAL HISTORY

Alcohol Intake ☐ Yes ☐ No

Frequency (e.g. daily, occasionally): ……………………………… Amount (glasses/bottles): ……………………………

Smoking ☐ Yes ☐ No

Number of Cigarettes per Day: ………………………………………………………………………………………………..

Please note: Smoking can delay your healing process after any surgery. It is recommended you stop smoking 2 weeks prior to your surgery.

***** SEE OVER PAGE FOR FURTHER DETAILS**

REPRODUCTIVE HISTORY

Last Menstrual Period: ………

Contraceptive Pills: ☐ Yes ☐ No Last Taken: ……………………………..…………...

Last Pregnancy: ☐ Normal ☐ Caesarean Section Year: ……………………...……………………..

Number of Children: ……

Plans for Future Pregnancy: ☐ Yes ☐ No

WEIGHT LOSS HISTORY

Appetite Suppressants	How many?
Present Weight	
Maximum weight in adulthood?	Details of any other weight loss Measures:
Minimum weight in adulthood?	Was there any particular event that lead to significant weight gain:
What is your preferred date for surgery?	Will you come alone/partner/group?

GASTROESOPHAGEAL REFLUX / INDIGESTION

Do you have a history of heartburn or indigestion?

If yes, how often do you have reflux during the day?

Do you suffer heartburn / indigestion during the night?

What aggravates or causes your reflux?

Do you have difficulty swallowing?

Does food ever get stuck?

Does food or fluid reflux into the mouth?

Do you vomit with reflux?

Do you suffer from recurrent sore throats?

Do you suffer from a hoarse voice?

Who is your travel arranger?

How did you hear about us?

Have you had Covid, and when was this?

Thank you for your time. Please go the declaration of the next page and fill in the details.
This form is to be sent back so that we may ensure you are a candidate for Bariatric Surgery.
Please remember we will need copies of a blood test and ECG test a month prior to your surgery

TERMS AND CONDITIONS

- I hereby acknowledge that the questions on this form have been answered truthfully.
- It is my responsibility to inform Dr Arias Giovanni of any change in my medical status.
- I fully understand that providing incorrect and/or incomplete information can lead to:
  (1) Serious risks to my health;
  (2) Cancellation of my treatment(s);
  (3) Extra pre-operative and post-operative treatment(s) and/or examination(s) necessary for my condition(s); and
  (4) Additional cost of the treatment(s) and/or examination(s) stated in (3).
- If you have or had any health condition, you are willing to send Dr Arias Giovanni your medical history along with this form.

☐ **I accept the terms and conditions stated above.**

[______________________________]
(Signature)

DATE: …../……/……