CONSIDERING WEIGHT LOSS SURGERY

Title: _____ Date: _____

Name: _____ Telephone: _____

Email: _____ Occupation: _____

Medical History

Allergies: _____

Reflux	Y	N	Medication
Sleep aponea	Y	N	Medication
Hypertension	Y	N	Medication
High cholesterol	Y	N	Medication
Diabetes/insulin resistance	Y	N	Medication
Gallbladder disease	Y	N	Medication
Kidney disease	Y	N	Medication
Heart disease	Y	N	Medication
Osteoarthritis	Y	N	Medication
Polycystic ovary syndrome	Y	N	Medication
Cancer	Y	N	Medication
OTHER CONDITIONS	Y	N	Medication

Weight History:

Current weight: _____kg Height: _____ BMI: _____ (if known)

Start of weight problem: _____Maximum weight reached: _____kg

Previous diets or attempts to lose weight: _____

Do you exercise on a regular basis: **(Y) (N)** If yes how often? _____

Eating habits: Regular 3x meals a day **(Y) (N)** Volume eating **(Y) (N)** Grazing/snacking **(Y) (N)**

What are your expectations about weight loss surgery? _____

What are your goals and motivations? _____

_____

Do you know anyone who have had weight loss surgery? **(Y) (N)** Who? _____

Social History:

Do you smoke? **(Y) (N)** if yes how many cigarettes per day? _____

Do you drink alcohol **(Y) (N)** if yes how many drinks per week? _____

How did you hear about us: GP Specialist Family Friend Website Social Media

PRIVATE POLICY: This practice conforms to the requirements of the current Federal Privacy Legislation. A copy of our privacy policy is available on request. A record of your consultation and examination will be made and retained as part of this process.

I consent to the taking of photographs before and after surgery and understand they are not to be used for any purpose other than to keep track of my weight loss journey in Dr John Jorgensen's practice.

Signature: **Date:**