PORT LAPSURGERY
MID NORTH COAST BARIATRIC & HERNIA CENTRE

# New Patient Assessment Form

**Private & Confidential**

Today's date: _____

Name: _____ Date of birth: _____

Address: _____

Home phone: _____ Mobile: _____ Work: _____

Email: _____

How did you hear about us? Select one

GP or referring doctor: _____

Medicare number: _____ No. on card: _____ Exp. Date: _____

Private health fund: _____ Member number: _____

Next of Kin: _____ Mobile: _____ Relationship: _____

## Social History

With whom do you live? _____

Current occupation? _____ Do you work night shifts Select

Do you identify as Aboriginal or Torres Strait Islander? Select

For how many hours a day are you employed outside the home? _____

How many hours of TV do you watch a day? _____ Day ☐ Evening ☐ Late night ☐

If you have a disability could you please share this with us in order to improve your experience?

_____

Could someone help care for you if you became seriously ill? Select

Are you the primary care giver for someone else (e.g. dependant children, parents)? Select

Ages of your children _____ Planning a pregnancy in the next 2 years? Select

What do you love doing? _____

Does your weight affect participation in these activities? Select

How long have you been overweight? _____ Obese before puberty? Select

Your lifetime maximum weight? _____ When was that? _____

Current weight: _____ Height: _____ Neck Circumference: _____

What is your BMI? _____ see BMI calculator at www.portlapsurgery.com.au

If BMI is under 35, complete the Navy Body Fat Calculator at www.type2diabetestreatment.com.au

What is your body fat percentage? _____ (from Navy Body Fat calculator)

How long have you been considering surgery? _____

Which procedure are you interested in and why?

_____

Your main sources of information about bariatric metabolic surgery

_____

Do you know others that have had a bariatric metabolic operation? Select

Do you know where they have had their surgery? _____

Do you have family and friends supportive of your decision to pursue this surgery? Select

Have you watched the patient video blog on our website? Select **Please watch prior to appointment**

## Lifestyle Assessment

Do you eat breakfast? Select What do you usually eat? _____

How many glasses of water do you have each day? _____

How many meals and snacks do you eat on a typical day? meals _____ snacks _____

Do you eat when you are not necessarily hungry i.e. non-hungry eating? Select

How many times per week do you eat out or get take-away food? _____

What types of takeaway or convenience food? _____

Approximately what proportion of your food comes out of a package or the frozen food section?

30% or less ☐ about 50% ☐ 70% or more ☐

How many servings of fresh fruits and vegetables do you eat daily (a serving is about the size of your fist)

_____ servings daily. Your favourites: _____

White or whole grain bread, which do you choose? white ☐ whole grain ☐

How many times a week do you eat red meat (like beef or lamb)? _____ times per week

How many times a week do you eat fish or other types of seafood or vegetarian sources of protein like beans or lentils? _____ times per week

Do you snack during TV/screen time? Select Favourite snack _____

Do you regularly eat desserts or sweet foods like lollies or chocolate? Select

If yes, how many times a day? _____ times per day. Preferred choices: _____

How many sugary or artificially sweetened beverages, sports drinks/juice do you typically consume each day? _____ cans/glasses per day

How many alcohol-containing drinks do you consume on a typical day? _____ drinks per day

Do you drink at parties? Select How often? _____

Preferred alcoholic beverage? _____

Have you ever binged on alcohol? _____

Have you ever used it to excess for long periods of time? Select When? _____

Are there any situations or times of day when you find it more diffcult to make healthy food choices or when you consume more food than you had planned? Please describe this scenario:

_____

_____

Do you usually shop for and cook your own food? Select

If yes, what do you like to cook?

_____

_____

Do you follow a special diet, eat or limit certain foods for health or other reasons? Select

If yes, please describe: _____

How willing are you to make changes in what, how or how much you eat in order to eat healthier and have a beneficial outcome after surgery?
(Select the number that best describes how you feel)

Very willing = 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐ = Not at all willing

How willing are you to incorporate exercise in to your routine as a **lifelong** commitment?
(This exercise may be typically regular walks, swimming, aqua aerobics, sport or gym)
(Select the number that best describes how you feel)

Very willing = 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐ = Not at all willing

* This form is adapted from earlier assessment tools by Lisa Hark PhD, RD and Darwin Deen MD and the REAP (Rapid Eating and Assessment Tool for Patients)

## Diet History

Have you used any of the following methods to control your weight? Please tick.

☐ Bingeing and vomiting
☐ Bingeing followed by food restriction
☐ Vomiting
☐ Laxatives
☐ Diuretics

Have you ever tried: Optifast ☐ Formulite ☐ Optislim ☐ Premium ☐ Feelgood Shake ☐ Other ☐

When? _____

List some diets or methods that you have tried in the past

| Diet or method used | Approx year | Number of kilos lost |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Have you had previous weight loss surgery? Select Type of surgery? _____

*Please complete the Revision Surgery: Life After Bariatric Metabolic Surgery form

Where did you have your surgery? _____ With Dr. _____

Have you ever seen a dietitian or diabetic educator? Select Approx date _____

If so, please provide name of dietitian: _____

## Exercise

Are you able to exercise? Select

If no what is the reason? _____

How would you describe your regular exercise pattern? Select from the options below

- ☐ No exercise (sedentary)
- ☐ Mild exercise (i.e. climb stairs, walk 3 blocks)
- ☐ Occasional vigorous exercise (i.e. physical work/ recreation, less than 4 times/week for 30 mins)
- ☐ Regular vigorous exercise (i.e. physical work or recreation, 4 times a week for 30 mins)

Describe the exercise activities you take part in? _____

If you do no exercise, what is the most strenuous activity that you do in a typical week? If chores, please specify _____

Which of the following can you do without stopping to rest?

- ☐ Walk to a building from a distant parking space?
- ☐ Climb 1 flight of stairs
- ☐ Climb 2 flights to stairs
- ☐ None of the above

Do you have mobility issues because of your weight? Select

Do you have frequent falls because of your weight? Select

Can you walk more than 50m without assistance? Select

Assistance required (please select):

*Our clinic is designed to assist those with mobility issues providing ramps, wide doors, bathrooms and weight bearing chairs to make your visit more comfortable.

## Medical History

Please list any diagnosed medical problems with a brief explanation. Your doctor will include any important issues in your referral.

_____

_____

If you have been diagnosed with Type 2 Diabetes or as *prediabetic* when did you receive this diagnosis and from whom? _____

Please list any significant health issues present in your family.

_____

_____

Please enter any medications you are currently taking in the table below.

Please include prescribed drugs and over the counter drugs such as vitamins etc

| Name | Strength | Frequency taken |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Are you on any pain medications or medications such as opioids? Select Please list:

_____ Date started? _____

What dose would you take on an average day? _____

The main reason why? _____

Who prescribed this medicine? _____

Have you had an allergic reaction to a medication? Please provide details:

_____

Have you ever suffered from reflux or heartburn? Select When? _____

What symptoms do you experience? _____

How often do you experience symptoms ? _____

How long have you had these symptoms? _____

Are you on medication for reflux/ heartburn? _____

What happens if you forget to take your medication? _____

Does the medication control the symptoms? Select

Have you been diagnosed with sleep apnoea Select

Do you snore louder than talking, loud enough to be heard through closed doors? Select

Do you often feel tired, fatigued or sleepy during daytime? Select

Has anyone observed you stop breathing during your sleep? Select

Do you have or are you being treated for high blood pressure? Select

Is your BMI greater than 35 kg/m$^2$? Select

Are you older than 50 years old? Select

Are you male? Select

Is your neck circumference greater than 40cm? Select

Please list any previous surgeries you have had **/ 8**

| Year | Surgery & reason | Hospital |
|---|---|---|
| | | |
| | | |
| | | |

Please list any other hospitalisation

| Year | Reason | Hospital |
|---|---|---|
| | | |
| | | |
| | | |

Have you had a recent gastroscopy or colonoscopy Select Date: _____

Have you ever had a blood transfusion

Have you ever smoked Select

- Yes, but I quit in _____ I smoked _____ packs per day for _____ years
- Yes, I currently smoke ____ packs per day and have smoked for _____ years
- Yes, I currently vape ____ times per day and ____ vapes per session

Do you currently use recreational or street drugs including marijuana? Select

Have you ever given yourself street drugs with a needle? Select When? _____

## Mental Health

Have you been formally diagnosed with a mental health condition? Select

If yes, what is your diagnosis? _____ Diagnosed by: _____

Are you medicated for this diagnosed condition? Select

Have you ever been admitted to a mental health unit? Select When? _____

Do you eat when stressed or anxious? Select

Do you cry frequently? Select

Have you ever seriously thought about hurting yourself? Select

Have you ever attempted suicide? Select

Do you have trouble sleeping? Select

Why do you think this is the case? _____

Have you ever been to a psychiatrist, psychologist or counsellor? Select

If yes, their name _____ Last appointment _____

Do you seek regular treatment to manage your mental health? Select

What type of strategies have helped you? _____

Are you currenty using any strategies? What are they? _____

Will you see a mental health professional if recommended by our clinic or your GP? Select

Have you ever felt picked on because of your weight? _____ What age/s? _____

What do you consider your personal strengths? (eg. optimism, resilience, kindness, hard working etc.)

_____

Are you prepared to join our online support group and reach out for support when needed? Select

If no, why? _____

Facebook: Port Lapsurgery Bariatric Support Group

Are you prepared to attend a support group if recommended? Select

## Finance

Do you have private health insurance? Select

Does your policy cover you for Bariatric Metabolic Surgery? Select
(this may be called Weight Loss Surgery on your policy)

Are you within a wait period? Select If so when is it up? _____

Which of the following options are you planning on using to cover the gap?

TLC ☐ Other finance ☐ Superannuation ☐ Own resource ☐

**Your privacy is important to us and this document will be treated with care.**

Please return this questionnaire by email, mail or fax

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