Dr Mikhail MASTAKOV MD, FRACS
Weight Loss & General Surgery
Laparoscopic Emergency & Elective

Cleveland House Visiting Specialist Centre
Suite 22 Cleveland House
120 Bloomfield Street
CLEVELAND Q 4163

Sunnybank Clinic
Specialist Centre
Suite 22, Level 1
245 McCullough Street
SUNNYBANK Q 4109

NEW ADDRESS
Hervey Bay Clinic
ST STEPHEN'S Hospital
Ground Floor Specialist Suites
1 Medical Place
URRAWEEN Q 4655

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Weight Loss Surgery Health Questionnaire and Initial Consultation Record (5 pages)

As part of our service we would appreciate it if you could take the time to fill in the following questionnaire prior to your first appointment. This helps us to gain information about your general health so that we can make sure to plan the best outcome for you.

Title: _____ Family Name: _____ First Name: _____
Date of Birth: _____/_____/_____ Gender: _____
Occupation: _____Contact Phone Number: _____
Address: _____
Email Address: _____
Next of Kin: _____ Contact No: _____
Medicare Number: _____ Ref. No: ____
Private Health Fund: _____ Membership No: _____

1. Type of surgery planned or being considered: *(please tick)*

□ Lap Adjustable Band	□ Sleeve Gastrectomy	□ Gastric Bypass (Roux en Y)
□ Revision surgery	□ Other:	

2. Reasons you are interested in Bariatric surgery: *(please tick)*

□ Health benefits	□ Treatment of Sleep Apnoea	□ Improve Diabetes control
□ Increase energy	□ Increased sense of wellbeing	□ Improve mobility
□ Lower risk of Heart Attack	□ Improve blood pressure	□ Improve Reflux (GORD)
□ Being able to do more with grandchildren	□ Improve Arthritis knees/back	□ Other:

***3.* Weight Loss History:**

Current weight: _____ kg Height: _____ cm **BMI:** _____ (Dr Mastakov to complete)
Heaviest weight: _____ kg Lowest weight: _____ kg
Onset of Obesity: Childhood / Adolescence / Adulthood *(circle most appropriate)*
Have you tried to lose weight in the past? Yes / No / Not sure *(circle most appropriate)*
If Yes please list below:

Program Type (e.g. diet or program)	Details (effectiveness, weight change, duration)
_____	_____
_____	_____

4. Current Doctors: Your local doctor (GP) and Medical Clinic Name & Location:

_____
_____

Do you have a specialist/s whom you attend? Yes / No / Not sure *(circle most appropriate)*
If Yes please list below:
Do you give consent for us to obtain your medical history from these Specialists? Yes / No
If insufficient space, please attach a separate page

Name of Specialist	Type (e.g.Physio, psychologist, heart, lung, kidney, nutritionist)

5. Current Medication/s: *(please state the generic/ non brand names of medications where possible) If insufficient space, please attach a separate page*

Name of medication	Dose/ Strength	Frequency (per day)

Do you take any Contraceptive medications (female) *(circle most appropriate)* Yes /No / Not sure

Do you take any Blood Thinners or Anti-Clotting medications? Yes /No/ Not sure

If Yes please tick below:

□ Warfarin	□ Pradaxa	□ Eliquis	□ Xarelto
□ Plavix	□ Asasantin	□ Other:	

6. Surgical History: *If insufficient space, please attach a separate page*

List of Past Surgeries	Year and Other Details

7. Medical History: *(circle most appropriate)*

Coronary Heart Disease?	Yes / No / Not sure	Chest pain?	Yes / No / Not sure
Heart Attack or Angina?	Yes / No / Not sure	High Cholesterol?	Yes / No / Not sure
High Blood Pressure or Hypertension?	Yes / No / Not sure	Irregular heart beat or Atrial Fibrillation?	Yes / No / Not sure
Breathing problems or shortness of breath?	Yes / No / Not sure	Anaemia (low red cell count)?	Yes / No / Not sure
Stroke?	Yes / No / Not sure	Asthma or COPD?	Yes / No / Not sure
Chronic cough?	Yes / No / Not sure	Sleep Apnoea?	Yes / No / Not sure
***Diabetes?**	Yes / No / Not sure	Neuropathy or numb feet?	Yes / No / Not sure
Vision problems?	Yes / No / Not sure	Thyroid Disease?	Yes / No / Not sure
Seizures or Epilepsy?	Yes / No / Not sure	Migraines?	Yes / No / Not sure
Bleeding Disorder?	Yes / No / Not sure	Blood clots or DVT?	Yes / No / Not sure
Arthritis?	Yes / No / Not sure	Chronic back pain?	Yes / No / Not sure
Autoimmune Disease?	Yes / No / Not sure	Fractures or Osteoporosis?	Yes / No / Not sure

Reflux or Heart Burn?	Yes / No / Not sure	Fatty Liver?	Yes / No / Not sure
Abnormal liver blood cells?	Yes / No / Not sure	Cirrhosis of the liver?	Yes / No / Not sure
Bowel Cancer or Polyps?	Yes / No / Not sure	Hepatitis?	Yes / No / Not sure
Irritable Bowel Syndrome?	Yes / No / Not sure	Infertility?	Yes / No / Not sure
Chronic nausea or vomiting?	Yes / No / Not sure	PCOS (females): Polycystic Ovary Syndrome?	Yes / No / Not sure
Kidney Stones?	Yes / No / Not sure	Kidney Disease?	Yes / No / Not sure
Urine Incontinence?	Yes / No / Not sure	Prostate Enlargement (males)?	Yes / No / Not sure
Recurrent Urinary Infections?	Yes / No / Not sure	Other:	

If Yes to **Diabetes please circle below:*

Home finger prick testing – Usually under	Yes / No / Not sure 10mmon/L	Last Hba1c result on blood tests higher than	Yes / No / Not sure 8.0%

Family history of Cancer or Heart Attack before 55 years of age: Yes / No / Not sure
Developmental history of traumatic life event/s such as abuse, loss or neglect that might affect your goals for weight loss or your ability to cope after surgery: Yes / No / Not sure

8. Exercise Tolerance: *(circle most appropriate)*
How far can you walk on a flat surface? _____meters / Unlimited / Unsure
When you need to stop is this normally due to? Trouble breathing / Pain / Fatigue / Other
Without stopping you can normally walk: *(please tick)*

□ More than 2 flights of stairs		□ 2 flights of stairs
□ 1 flight of stairs	□ Half a flight of stairs	□ Around the house

9. Smoking History: *(circle most appropriate)*
Are you a Current smoker? Yes / No Are you a Past smoker? Yes / No
Are the years you smoked all together greater than 10? Yes / No / Not sure

10. Alcohol History: Current average alcohol intake per week:_____
Past alcohol abuse or dependency: Yes / No / Not sure *(circle most appropriate)*

11. Psychiatric or Mental Illness History: *(please tick)*

Have you ever been diagnosed with:	Year of Onset	Specialist/ Psychiatrist/ Psychologist	Controlled? *(please circle)*	When was it last reviewed?
□ Depression			Yes / No / Not sure	
□ Anxiety			Yes / No / Not sure	
□ ADHD			Yes / No / Not sure	
□ Bipolar Disorder			Yes / No / Not sure	
□ Eating Disorder Type:_____			Yes / No / Not sure	
Other:				
			Yes / No / Not sure	
			Yes / No / Not sure	

12. Allergies: *If insufficient space, please attach a separate page*

Allergen	Reaction or symptoms
_____	_____
_____	_____
_____	_____
_____	_____

13. Investigation History: *(circle most appropriate)*

Have you had any of the following investigations done in the last 3 months?		Investigations ordered by Doctor after the initial consultation: (Doctor Use Only)
Blood Tests	Yes / No / Not sure	
ECG (Electrocardiogram)	Yes / No / Not sure	
Chest X-ray	Yes / No / Not sure	
Breathing Tests or Spirometry	Yes / No / Not sure	
Sleep Study	Yes / No / Not sure	
Cardiac Stress Test	Yes / No / Not sure	
Liver Imaging/ Scan	Yes / No / Not sure	
Echocardiogram or Heart Scan	Yes / No / Not sure	
Prescription for "CLEXANE" and	"NEXIUM"	
Co-Hb blood or Cotinine Urine		

14. Doctor's Notes (Dr Mastakov to complete)**:**

Management Plan and Theatre Booking
_____ _____ _____ _____ _____ _____ _____

Health Information Collection and Use Consent Form

Please read this consent form carefully, and sign where indicated below.

As a patient of our medical practice we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs.
We aim to protect the privacy and secure storage of your health information in accordance with the Privacy Act. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information. We require your consent to collect personal information about you and to use the information you provide in the following ways:

- Deliver the health services and treatment to the patient.
- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors and specialists 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 referrals.
- Disclosure to other doctors in the practice, locums, etc. attached to the practice for the purpose of patient care and teaching.
- Disclosure to The Bariatric Surgical Registry (Monash University Melbourne VIC 3004 Australia https://www.monash.edu/medicine/sphpm/registries/bariatric). The primary aim of the Registry is to measure outcomes for patients undergoing bariatric surgery across public and private hospitals in Australia and New Zealand for the purpose of monitoring and evaluating patient outcomes across Australia and New Zealand.
- Comply with any legislative or regulatory requirements eg notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.

The information I have supplied in this questionnaire is accurate to the best of my knowledge	☐
I have read the information above and understand the reasons why my information must be collected.	☐
I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.	☐
I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.	☐

Cancellation Notice: I agree to give 48 hrs notice for cancellation of an appointment and/or a procedure, otherwise I will be charged a fee of $50 for an appointment and/or a procedure.	☐

Patients Name_____ Date____/____/_____

Patient's signature_____

Signed as Guardian for child_____ Name (printed) _____

COMMUNICATION BY EMAIL: Dr Mastakov and his staff are required by law to protect the privacy of your personal and health information. However, in our modern society most people expect to communicate in the most efficient way available and this usually involves the use of emails. Email transmissions are not secure and there is a risk that emails and their attachments may be intercepted and read by others.

By providing your email address and signing this form, you are acknowledging that, while we will do our best, we cannot ensure that any emailed information or attachments will remain private and secure. You are also giving Dr Mastakov and his staff permission to communicate with you by email and to forward information and documentation to you by email. We will use the email address you have provided to us until such time as you provide us with an alternative email address.

Patients Name_____ Date____/____/_____

Patient's signature_____

Signed as Guardian for child_____ Name (printed) _____