

# 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

**Hervey Bay Clinic**  
ST STEPHEN'S Hospital  
Ground Floor Specialist Suites  
1 Medical Place  
URRAWEEEN Q 4655

Telephone: 07 34143950 and 07 4148 7082

Fax: 07-33196338

Email: mmastakov@mastakovsurgery.com

Website: <http://mastakovsurgery.com.au/>

## 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: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Contact Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Next of Kin: \_\_\_\_\_ Contact No: \_\_\_\_\_

Medicare Number: \_\_\_\_\_ Ref. No: \_\_\_\_\_

Private Health Fund: \_\_\_\_\_ Membership No: \_\_\_\_\_

### COVID Vaccination Information:

Unvaccinated  1 Dose only  Fully Vaccinated (2-3 Doses)

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

<input type="checkbox"/> Lap Adjustable Band	<input type="checkbox"/> Sleeve Gastrectomy	<input type="checkbox"/> Gastric Bypass (Roux en Y)
<input type="checkbox"/> Revision surgery	<input type="checkbox"/> Other:	

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

<input type="checkbox"/> Health benefits	<input type="checkbox"/> Treatment of Sleep Apnoea	<input type="checkbox"/> Improve Diabetes control
<input type="checkbox"/> Increase energy	<input type="checkbox"/> Increased sense of wellbeing	<input type="checkbox"/> Improve mobility
<input type="checkbox"/> Lower risk of Heart Attack	<input type="checkbox"/> Improve blood pressure	<input type="checkbox"/> Improve Reflux (GORD)
<input type="checkbox"/> Being able to do more with grandchildren	<input type="checkbox"/> Improve Arthritis knees/back	<input type="checkbox"/> 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)



Stroke?	Yes / No / Not sure	Asthma or COPD?	Yes / No / Not sure
Chronic cough?	Yes / No / Not sure	Sleep Apnoea?	Yes / No / Not sure
<b>*Diabetes?</b>	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 10mmol/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. 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

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

**10. Use of Recreational Drugs History:** Current recreational drugs abuse or dependency: Yes / No / Not sure (circle most appropriate)  
 Past recreational drugs 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?
<input type="checkbox"/> Depression			Yes / No / Not sure	
<input type="checkbox"/> Anxiety			Yes / No / Not sure	
<input type="checkbox"/> ADHD			Yes / No / Not sure	
<input type="checkbox"/> Bipolar Disorder			Yes / No / Not sure	
<input type="checkbox"/> Eating Disorder			Yes / No / Not sure	
Type:				
Other:				
			Yes / No / Not sure	
			Yes / No / Not sure	

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

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

**13. 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)*

<input type="checkbox"/> More than 2 flights of stairs	<input type="checkbox"/> 2 flights of stairs
<input type="checkbox"/> 1 flight of stairs	<input type="checkbox"/> Half a flight of stairs
	<input type="checkbox"/> Around the house

**14. 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	

**15. 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	<input type="checkbox"/>
I have read the information above and understand the reasons why my information must be collected.	<input type="checkbox"/>
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.	<input type="checkbox"/>
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.	<input type="checkbox"/>
<b>Cancellation Notice:</b> 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.	<input type="checkbox"/>

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) \_\_\_\_\_