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
URRAWEEN Q 4655

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General Surgery Patient Questionnaire and Initial Consultation Record (4 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	First Name:		Middle Name:	Last Name:		
Occupation			Date of Birth			
Postal Address						
	Suburb/City		State		Post Code	
Phone Nº	Home:		Work:	Mobile:		
I am able to receive an **SMS on my mobile** to confirm my Appointment/Surgery: ☐ Yes ☐ No						
Email Address:						
Your GP's Name, Address & Phone No:						
COVID Vaccination Information: ☐ Unvaccinated ☐ 1 Dose only ☐ Fully Vaccinated (2-3 Doses)						
Next of Kin & Phone Number:						
Medicare Nº				Ref Nº		
Private Health Fund Name				Mbr. Nº		
DVA card Nº				Card Type	Gold/White/Orange	

1. List **all medications** you are currently taking (including over the counter, herbal/alternative medicines and/or pain killers). State dosage and strength: *If insufficient space, please attach a separate page*

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2. List **previous operations** you have had including approximate dates: *If insufficient space, please attach a separate* page.

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____

3. Have you, or a relative had any **complications** with an anaesthetic or operations? *If yes, give details*: Yes ☐ No ☐

____
____
____
____

4. Do you have any **allergies** to medications, latex, rubber and/or tropical fruits? *If yes, give details and the nature of the reaction*: Yes ☐ No ☐

____
____
____
____

5. Do you currently have, or ever had, any of the **following conditions**? (*Circle the specific condition and mark the applicable box with X*)

	Yes	No
• Angina / Coronary Disease / Heart Attack / Cardiac Surgery / Pacemaker___________	☐	☐
• Rheumatic Fever / Heart Murmurs / Palpitations ______________________________	☐	☐
• High Blood Pressure____	☐	☐
• Asthma / Chronic Bronchitis / Emphysema / Tuberculosis / Other Lung Disease_____	☐	☐
• Sleep Apnoea____	☐	☐
• Cough, Cold or Flu in the past 3 weeks____________________________________	☐	☐
• Blood Clot in the Legs or Lungs (Thrombosis or Embolism)____________________	☐	☐
• Do you take Aspirin, Clopidogrel (Iscover/Plavix) or Warfarin___________________	☐	☐
• Stroke / Blackouts / Fits / Epilepsy____	☐	☐
• Mental Health Condition eg. Depression, Schizophrenia______________________	☐	☐
• Heartburn / Gastric Reflux / Hiatus Hernia / Peptic or Duodenal Ulcer_____________	☐	☐
• Bowel Problems eg. Diverticulitis, Crohn's ________________________________	☐	☐
• Hepatitis / Jaundice / Liver Disease______________________________________	☐	☐
• Diabetes (Please circle treatment) Insulin / Tablets / Diet______________________	☐	☐
• Have you recently taken Steroid medication (Cortisone / Prednisone)? ___________	☐	☐
• Arthritis / Muscles Disease____	☐	☐
• Do you have difficulty walking up a flight of stairs or 1 Kilometre on the flat? ______	☐	☐
• Any inherited disorder (eg. Porphyria, Haemochromatosis, Thalassemia)__________	☐	☐
• Kidney/Bladder problems____	☐	☐
• Are you pregnant? ____	☐	☐
• Do you get motion sickness? ____	☐	☐
• Have you been overseas within the last 2 weeks? ___________________________	☐	☐
• **Do you smoke**? If yes, How many per day_________________________________	☐	☐
• Have you ever smoked? If yes, when did you cease? __________________________	☐	☐
• **Do you use recreation drugs**? If yes, which drug(s) and how often:	☐	☐

____
____
____

• **Do you consume Alcohol**? _______________________________ Yes ☐ No ☐
If yes, how often: ☐ Daily ☐ Weekly ☐ Monthly
and how much? _______________________________

- Do you wear or have any of the following: (*please circle*)

Hearing Aid	Contact Lenses	Artificial Eye	Denture(s)
Loose Teeth	Dental Bridges	Crowns	Caps
Other Prostheses			

- Do you have any other health problems of which you feel your Surgeon and Anaesthetist should be aware? *If Yes, please give details* Yes No

- What is your Weight ?: ________kg
- What is your Height ?: ________cm

6. Any **additional Information**:

7. **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.
- 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) _______________________