



Personal Details		
Title:	Surname:	Given name:
Address:		
Suburb:	Postcode:	
DOB:		
Mobile:	Home Phone:	
Email:	Work Phone:	
Medicare/Private Health Fund		
Medicare Number:	Patient Ref No:	Expiry:
Hospital Fund:	Membership Number:	
Cover: GOLD SILVER BRONZE Other (circle)	Have you served waiting period:	
DVA Veteran: Gold White (circle)	DVA number:	
Work Cover/TAC:		
Next of Kin		
Surname:	Given Name:	
Contact number:	Relationship:	
GP Details		
Name:	Phone number:	
Clinic:		

Medical History		
Current height and weight?	Height (cm)	Weight (kg)
Are you a current/past smoker?	☐ Yes	☐ No
If yes, how many do you smoke a day?		
If past, when did you cease?		
Do you drink alcohol?	☐ Yes	☐ No
If yes, volume:		
Are you Diabetic?	☐ Yes	☐ No
If yes, please circle: TYPE 1 TYPE 2		
Do you have a history of heart disease?	☐ Yes	☐ No
Details:		
Do you have a pace maker or internal defibrillator?	☐ Yes	☐ No
Details:		
Do you have Reflux or Heartburn?	☐ Yes	☐ No
Do you have High Blood Pressure?	☐ Yes	☐ No
Do you have any respiratory / breathing problems?	☐ Yes	☐ No
Details:		
Do you have Sleep Apnoea?	☐ Yes	☐ No
If yes, do you use a CPAP machine (please circle) YES NO		

Medical History continued		
Allergies:	☐ Yes	☐ No
Details:		
Have you had previous weight loss surgery with another surgeon?	☐ Yes	☐ No
Details:		
Have you had any other previous surgeries? (e.g. gallbladder removal)	☐ Yes	☐ No
Details:		
Do you have any other medical conditions?	☐ Yes	☐ No
Details:		
Please list other methods of weight loss that you have tried (e.g. diet plans, exercise, medication):		



Border Surgical Current Medication List

The medications that you are on may affect the outcome of any upcoming surgery.

Please complete this form so that your medications, including herbal medications, can be assessed. If required, you will be advised of medication you will need to cease prior to surgery. In some cases, an alternative medication will be organized.

If you are not on any medications, please write NA.

Please ensure you sign and date this form.

Name (please print): _____ **DOB:** ____/____/____

Signature: _____ **Date:** ____/____/____

MEDICATION NAME	DOSAGE