Dr V. Kuzinkovas

Advanced Surgicare

Patient Information

(Please Print)

Personal Details	
Surname:	First Name:
DOB:	Age:
Address:	
	P/Code:
Home Phone:	Mobile:
Work Phone:	Email:
	Can we use this email to contact you regarding your treatment?
	Yes: ☐ No: ☐
Occupation:	Religion:
Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐ Defacto ☐	
Children:	
Are you an Australian Resident: Yes ☐ No ☐	
Country of Birth:	If Australia, specify state:
Are you of Aboriginal/Torres Strait Islander (TSI) descent? No☐ Aboriginal☐ TSI☐ Both☐	

Other Contact (Spouse, Partner, Parent, Other Relative, Friend)	
Name:	Relationship:
Address:	
	P/Code:
Home Phone:	Mobile:
Work Phone:	Email:

Insurance		
Medicare:	Ref # :	Exp. Date:
Health Fund:	Membership # :	
Pension:	Exp. Date:	
Veteran Affairs #:	DVA Card Colour:	

GP Details	
Name:	
Address:	
	P/Code:
Phone:	Fax:

Other Doctors / Specialists you see:		
Name:	Address:	Speciality:

Referral Details:
How did your hear about our Practice?:
Name of Referring Doctor:
Reason for Referral:

Our privacy policy is available for you should you wish to read it – please enquire at front desk

☐ *I acknowledge that I am aware that the Advanced Surgicare Privacy Policy is available at the front desk*

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Medical History

Personal History (Have you ever suffered from any of the following health problems?)			
Illness	Yes	No	Details:
Diabetes	☐	☐	Type I ☐ Type II ☐
Asthma	☐	☐	
Respiratory Problems/COPD	☐	☐	
Sleep Apnoea	☐	☐	Do you use a CPAP device? Yes ☐ No ☐
Stroke	☐	☐	
Depression	☐	☐	
Gallstones	☐	☐	
Heartburn / Reflux	☐	☐	
Hepatitis	☐	☐	
High Blood Pressure	☐	☐	
Heart Disease / Angina / Heart Attack	☐	☐	
High Cholesterol	☐	☐	
Clotting Disorder/Blood Clot	☐	☐	
Bipolar Disorder	☐	☐	
Anaemia	☐	☐	
PCOS	☐	☐	
Infertility	☐	☐	
Epilepsy	☐	☐	
Osteoarthritis	☐	☐	
Allergies	☐	☐	
Other: (Please specify)			

Other		
Have you ever smoked? Yes ☐	No ☐	If Yes, how many?
How long?	Have you/when did you stop?	
How many standard alcoholic drinks do you have per week?		

Surgical History (Please give details of any past operations, especially abdominal)	
Procedure:	Date:

Family History (Please list any conditions that run in your family)

Medications (Please state all medications that you are on)		
Medication:	Dose:	Duration:

Name:_____

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Weight Loss History

General Weight Loss Questions	
How long have you suffered with excess weight?	years
When were you at your heaviest?	
Approximately how heavy were you?	kgs
How long have you been seriously trying to lose weight?	years
What is the maximum weight lost by any method?	kgs

Which of the following have you tried?					
Dieting	Yes	No		Yes	No
Jenny Craig	☐	☐	Mediterranean Diet	☐	☐
Weight Watchers	☐	☐	DASH Diet	☐	☐
Sure Slim	☐	☐	5:2 Diet	☐	☐
Atkins	☐	☐	Ketogenic Diet	☐	☐
Liquid Diets	☐	☐	Flexitarian Diet	☐	☐
Diet Pills					
Duromine	☐	☐	Saxenda	☐	☐
Xenical (Orlistat)	☐	☐	Contrave	☐	☐
Professional Advice	☐	☐		☐	☐
Local Doctor	☐	☐	Hypnotherapist	☐	☐
Dietitian	☐	☐	Psychologist	☐	☐
Naturopath	☐	☐	Acupuncturist	☐	☐
Other:					

Previous Weight Loss Surgery	
Procedure:	Date:

Exercise		
Are you doing any regular exercise at the present time?	Yes ☐	No ☐
If yes, what type?		
How many hours per week?		

After your surgery, would you be willing to speak to other patients who are considering surgery?	Yes ☐	No ☐

OFFICE USE ONLY	
Height:	Weight:
BMI:	Goal Weight:
Excess Weight:	

Name:_____

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EARLY SUPER RELEASE

If you intend on applying for Early Superannuation release on compassionate grounds to fund your surgery, please fill in the information below.

(Please Print)

Full Name:
Superannuation Fund:
Super Fund Number:
Super Fund Address:
P/Code:
Super Fund Contact Phone:
I understand that if I access my superannuation early, I must use these funds to pay for my weight loss surgery. Failure to do so could result in fees and severe penalties from the Australian Tax Office. **I understand I may be asked for a copy of my current Driver Licence or proof of identity in case of an Australian Tax Office audit.**
Signature:

Dr Vytauras Kuzinkovas
Phone: 1300 551 533
info@advancedsurgicare.com.au
www.advancedsurgicare.com.au

PRIVACY INFORMATION CONSENT

The Privacy Act 1988 now requires all medical practitioners and related medico-scientific companies to obtain consent from their patients to collect, use and, in prescribed instances, disclose that patient's personal information.

Collection
This means we will collect information that is necessary to properly advise and treat you. Such necessary information may include full medical history, family medical history, contact details, Medicare/private health fund details, billing/account details. The information will normally be collected directly from you. There may be occasions when we will need to obtain information from other sources such as other medical practitioners such as GP's and specialists, nurses, hospitals and Day Surgery Units. Both our practice staff and the medical practitioners may participate in the collection of this information. In emergency situations we may need to collect personal information from relatives or other sources where we are unable to obtain your prior express consent.

Use and Disclosure
With your consent, the practice staff will use and disclose your information, for purposes such as account keeping and billing purposes, referral to another medical practitioner or health care provider, sending of specimens, such as blood samples, referral to a hospital for treatment and /or advice, advice on treatment options, the management of our practice, quality assurance, including development of a data base for surveillance of treatment outcomes, practice accreditation and complaint handling, to meet our obligations of notification to our medical defence organizations or insurers, to prevent or lessen a serious threat to an individual's life, health or safety, where legally required to do so, such as producing records to court, mandatory reporting of child abuse or the notification of diagnosis of certain communicable diseases. Your case may be discussed at a multi disciplinary meeting and this will generate a Medicare fee however no charge will be incurred to you.

Access
You are entitled to access your own health records at any time convenient to both yourself and the practice. Access can be denied where, access would create a serious threat to life or health, there is a legal impediment to access, the access would unreasonable impact on the privacy of another, your request is frivolous, the information relates to anticipated or actual legal proceedings and you would not be entitled to access the information in those proceedings, in the interests of national security. We ask that, where possible, your request be in writing. We may impose a charge for photocopying or from staff time involved in processing your request. Where you dispute the accuracy of the information we have recorded you are entitled to correct information. It is our practice policy that we will take all steps to record all of your corrections, and place them with your file but will not erase the original record.

Consent
I have read and understood this "Privacy Information Document" supplied by Advanced Surgicare Pty Ltd. I provide my consent for the collection, use and disclosure of my personal information as outlined above. I understand that I am entitled to access my own health records except where access would be denied as outlined above. I understand that I may withdraw my consent as to use and disclosure of my personal information (except when legal obligations must be met) but this may affect the ability of Dr Kuzinkovas to offer treatment.

I give permission for clinical photographs to be taken as part of my consultation	Yes	No
My clinical photographs may be used for medical education purposes (doctors/nurses/ medical students only)	Yes	No
My clinical photographs may be used for public education purposes	Yes	No
My consultation notes may be used in communication with other health professionals involved in my care	Yes	No
I would like to receive information and special offers from time to time	Yes	No

NOTE: If your personal details or medical condition ever changes in future, please ensure you advise us.

Name: _____ **Witnessed:** _____

Signed: _____ **Date:** _____

Dr Vytauras Kuzinkovas
Phone: 1300 551 533

Name……..

PSYCHOLOGICAL ASSESSMENT

Do you eat unusually large amounts of food at one sitting?	Yes	No	Sometimes
Do you eat when you're not hungry?	Yes	No	Sometimes
Do you eat until you're uncomfortably full?	Yes	No	Sometimes
Do you feel you've lost control and can't stop eating?	Yes	No	Sometimes
Do you feel ashamed or depressed after eating, like you are a failure, and/or you have sabotaged yourself?	Yes	No	Sometimes
Do you eat alone because you are embarrassed to eat around others?	Yes	No	Sometimes
While eating, do you feel comforted, relieved, like emotional pressure have been lifted or like you are more in control?	Yes	No	Sometimes

DASS 21 **Depression Anxiety Stress Scale** (0 – did not apply, 1 - applied to me to some degree or some of the time, 2 – applied to me a considerable degree or a good part of the time, 3 – applied to me very much or most of the time)

		N	S	O	AA	FOR OFFICE USE D	A	S
1	I found it hard to wind down	0	1	2	3			
2	I was aware of dryness of my mouth	0	1	2	3			
3	I couldn't seem to experience any positive feeling at all	0	1	2	3			
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathless in the absence of physical exertion).	0	1	2	3			
5	I found it difficult to work up the initiative to do things	0	1	2	3			
6	I tended to over-react to situations	0	1	2	3			

7	I experienced trembling (eg, in the hands)	0	1	2	3			
8	I found that I was using a lot of nervous energy	0	1	2	3			
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3			
10	I felt I had nothing to look forward to	0	1	2	3			
11	I found myself getting agitated	0	1	2	3			
12	I found it difficult to relax	0	1	2	3			
13	I felt down-hearted and blue	0	1	2	3			
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3			
15	I felt I was close to panic	0	1	2	3			
16	I was unable to become enthusiastic about anything	0	1	2	3			
17	I felt I wasn't worth much as a person	0	1	2	3			
18	I felt that I was rather touchy	0	1	2	3			
19	I was aware of the action of my heart in the absence of physical exertion (eg. Sense of heart rate increase, heart missing a beat)	0	1	2	3			
20	I felt scared without any good reason	0	1	2	3			
21	I felt that life was meaningless	0	1	2	3			
				TOTALS				