OHWC
Orange Healthy Weight Clinic

Patient Intake Forms

Contact Details

Given name/s: _____Surname: _____

Preferred name: _____ DOB: _____

Mobile number: _____ Home number: _____

Email address: _____

Residential address: _____ Postcode: _____

Suburb: _____ State:

_____ Medicare card number: _____ Expiry: ____/_____

Ref. No: _____ Concession (please circle): Pensioner Healthcare Veterans

None Concession card number: _____Expiry: ____/____/

_____ Country of birth: _____Language/s spoken:

_____ Ethnicity: _____Aboriginal/Torres

Strait Islander? YES / NO Interpreter needed? YES / NO

Occupation: _____

Next of Kin

First name: _____Surname: _____

Residential address: _____ Postcode: _____

Contact number: _____Relationship: _____

How did you hear about our clinic?

- ○ Facebook
- ○ Search engine (e.g., Google)
- ○ Website
- ○ Brochure
- ○ Sign
- ○ Personal recommendation
- ○ Referral letter: _____
- ○ Other: _____

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General Medical History

Who is your regular GP? _____

Clinic & suburb: _____

Medical history:

_____

_____

_____

Previous surgery:

_____

_____

Medications:

_____

_____

Allergies:

_____

_____

Do you smoke? YES / NO

Sleep

Do you have sleep apnoea? YES / NO

If yes, who is your sleep physician? _____

On average, how many hours of sleep do you get per night? _____

Do you snore? YES / NO

Has anyone told you that you stop breathing or have choking episodes overnight? YES / NO

Do you wake up feeling unrefreshed or can you fall asleep easily during the day? YES / NO

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Weight History

What is your heaviest (non-pregnant) weight? _____ kg

What is your lightest weight? _____kg What is your ideal weight? _____kg

Any family history of obesity in your family? _____

_____

Have you tried any of the following weight loss tools in the past? (Please tick all that apply):

- ○ Jenny Craig
- ○ Weight Watchers
- ○ Lite n' Easy
- ○ Michelle Bridges' program
- ○ Atkins diet
- ○ 5:2 diet
- ○ CSIRO Total Wellbeing diet
- ○ Ketogenic diet
- ○ Mediterranean diet
- ○ Very Low Calorie Diet (VLCD) e.g. Optifast, Formulite, Tony Ferguson, Kicstart
- ○ General diet and exercise

Weight Loss Medications:

- ○ Phentermine (Duromine)
- ○ Orlistat (Xenical)
- ○ Sibutramine (Reductil)
- ○ Topiramate (Topamax)
- ○ Liraglutide (Saxenda)
- ○ Semaglutide (Ozempic)
- ○ Other: _____

Weight Loss Surgery (please specify surgeon and when completed):

- ○ Gastric banding: _____
- ○ Sleeve gastrectomy: _____
- ○ Gastric bypass: _____
- ○ Other: _____

Do you have a history of eating disorders? _____

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How active are you?

- Extremely inactive or immobile – seated for most or all of the day (e.g., wheelchair bound, inactive, couch bound)
- Sedentary - seated for extended periods throughout the day (e.g., office worker)
- Moderately active - active and on-the-go kind of person (e.g., work in hospitality or healthcare, or moderate daily exercise)
- Very active - heavy manual labour for a job (e.g., builder, labourer, or intense daily exercise)
- Extremely active – (e.g., competitive marathon runner)

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? Even if you haven't done some of these things recently, try to work out how they would have affected you.

- Use the following scale to choose the **most appropriate number** for each situation:
- 0 = would **never** doze
- 1 = **slight chance** of dozing
- 2 = **moderate chance** of dozing
- 3 = **high chance** of dozing

Situation	Chance of Dozing
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g., work meeting, cinema)	
As a passenger in a car for half an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	

Orange Healthy Weight Clinic

Privacy Statement & Consent Form

Our clinic collects information from you for the primary purpose of providing quality healthcare. 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 healthcare needs. We require your consent to collect this personal information about you.

Please read the following information carefully and sign below when you have read and agreed:

We will use the information you provide in the following ways:

- Administrative purposes in running our practice
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
- Delivering information to you – appointment reminders, recall notices, health information, clinic information and services, results of tests, etc. This may be by SMS, secure email, phone or letters unless you tell us otherwise
- Disclosure to others involved in your healthcare, including treating doctors, ancillary practitioners and specialists outside this medical practice. This may occur through referral letters to other practitioners, or for medical tests and in the reports or results returned to us through referrals
- Disclose to doctors, ancillary practitioners, locums and GP registrars attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records accessed for these purposes and we will note in your record accordingly
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to 'opt out' of an involvement at any time.

By signing, you:

1. Understand that you are not obliged to provide any information requested of you, but that your failure to do so might compromise the quality of the healthcare and treatment given to you
2. Are aware of your right to access the information collected about you, except in some circumstances where access might legitimately be withheld. You understand that you will be given an explanation in these circumstances
3. Understand that if your information is to be used for any purposes other than those outlined above, your further consent will be obtained first; and
4. Consent to the handling of your information by this practice for the purposes outline above, subject to any limitations on access or disclosure of which I notify this practice

Name: _____DOB: ____/_____/_____

Signature: _____ Date: _____