Dr Ian Baxter M.B.B.S. F.R.A.C.S.
General and Laparoscopic Surgeon

PROVIDER NUMBER 0572719L

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Title:_____ First Name:_____Surname:_____

DOB:_____ Email:_____

Do your Smoke? Yes / No Do you drink Alcohol? Yes / No If yes, how often?_____

Medical Conditions

Do you have or have you ever had, the following conditions?

- ☐ Diabetes Controlled by: Diet / Tablets / Insulin
- ☐ Heart Murmur / Heart Disease
- ☐ Pacemaker or other HEART implant
- ☐ Epilepsy / fits / faints
- ☐ Cancer
- ☐ Stomach problems / Gastric ulcer / Indigestion / Reflux
- ☐ Heart Attack / Palpitations / Angina
- ☐ Lung Disease
- ☐ Hepatitis
- ☐ Blood disorder / bleeding
- ☐ Kidney problems

Medical History

Operations - Date (if known)

_____ _____

_____ _____

Any complications with previous surgery? Yes / No

Any complications with previous anaesthetic? Yes / No

Current Medications

_____

_____

_____

_____

Medical Allergies

_____

_____

_____

_____

Weight? (kg)_____

Height? (cm)_____

Your Privacy, Our Concern – Consent to use your personal information

Dr Ian Baxter and The Sunshine Coast Medical Weight Loss Centre complies with the Commonwealth Privacy Act and all other state and territory legislative requirements in relation to the management of personal information. We collect information that is necessary for the provision of your health care. Personal information obtained from you in your consultation may be used to provide information to various health services involved in supporting your health care management (e.g. pathology, radiology, hospitals or other specialists). We note in your medical record that your history has been reviewed and discussed with you.
If the patient lacks capacity to consent, a guardian may sign on their behalf, with additional risk considerations. *Please contact us if this situation arises.*
By signing, you affirm that the provided information is true and correct as of the date of completion. I have read and understood the Privacy Policy and understand my rights and responsibilities.

I hereby consent to my personal information being released as and when required.

_____ _____ _____

Signature
Patient / Guardian / Power of attorney (please circle)

Relation to patient
Guardian / Power of attorney

Date: