Peninsula Health

ABDOMINAL REDUCTION PATIENT PRE OUTPATIENT ASSESSMENT

PATIENT DETAILS	**PATIENT NAME:**			
	ADDRESS:			
	SUBURB:		**P/CODE:**	
	DATE OF BIRTH:		**AGE:**	

MEDICAL INFORMATION	**HEIGHT:** _____CMS **OR** _____FT _____INCHES		**WEIGHT:** _____ KGS
	HAS YOUR WEIGHT CHANGED MORE THAN 4KGS IN THE PAST?	☐ YES ☐ NO	**MAXIMUM WEIGHT:** _____ **MINIMUM WEIGHT:** _____
	HAS YOUR WEIGHT BEEN STABLE FOR THE PAST 6 MONTHS? ☐ YES ☐ NO		
	DO YOU SUFFER FROM BACKACHES?	☐ YES ☐ NO	**DO YOU SEE A PHYSIOTHERAPIST, CHIROPRACTOR ETC. FOR THIS?** ☐ REGULARLY ☐ OCCASSIONALLY ☐ NEVER
	DO YOU GET A RASH BENEATH ANY OVERHANGING SKIN? ☐ YES ☐ NO		
	DO YOU SUFFER FROM STRESS INCONTINENCE? ☐ YES ☐ NO E.g. lose bladder control when you cough, sneeze or jump?		
	HAVE YOU HAD LAP BAND/ GASTRIC REDUCTION SURGERY? ☐ YES ☐ NO		
	DO YOU HAVE SEPARATION OF YOUR ABDOMINAL MUSCLES? ☐ YES ☐ NO		
	DOES YOUR ABDOMEN INTERFERE WITH YOUR ACTIVITIES OF DAILY LIVING? ☐ YES ☐NO **IF YES, PLEASE SPECIFY?**		
	DO YOU SMOKE	☐ YES ☐NO If yes, how many cigarettes per day? _____	

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Please list all medications you take, including any drugs or medicine not prescribed by your doctor.

MEDICATIONS	NAME	DOSE	FREQUENCY

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	☐ Fulfils criteria. For outpatient appointment. Signed _____
	☐ Other _____