Initial Medical Assessment

Date of Birth: 20-Dec-1960

Presenting Complaint: overeating	g	
Measurement:		
Height: 157 cm	Neck: 0 cm	PR:
Weight: 86.9 kg	Waist: 0 cm	RR:
BMI: 35.3	Hip: 0 cm	BP: /
Ideal Weight: 56.6 kg	WHR: 0	
Excess Weight: 30.3 kg		
Current Health Status:		
She has no associated medical p	problems	
On review of systems there were	e no other relevant health problem	ns.
Current Medications:		
She is currently not under any m	edication	
Relevant family and past medi	cal or surgical history:	
Diabetes: Mother		
Heart Disease: Mother		
Hypertension: Mother		
Past history re health:		
There are no relevant history		
Allergies:		
She has no associated allergies	or special risk factor	
Physical Examination:		
Labs:		

Patient Name: Mrs. Onervaa Cudmore

Date of Consultation:

Investigations and Referrals:

There are no investigations planned
There are no referrals planned
Management Plan:
Dr Gresham Clapham FRACS
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