Melbourne Gastro Surgery
CENTRE FOR DIGESTIVE & WEIGHT LOSS SURGERY

Phone: 03 9466 7799 Fax: 03 8080 9849

MR ARUN DHIR, Upper GI, Laparoscopic and Endoscopic, General Surgeon

PATIENT REGISTRATION FORM

Mr/Mrs/Miss/Ms/Dr FAMILY NAME: _____

GIVEN NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

_____ POSTCODE: _____

TELEPHONE: Home: _____ Work: _____

Mobile: _____ Email: _____

Please select: YES /NO - to be contacted via email in the future

OCCUPATION: _____

NEXT OF KIN: _____ PHONE NO: _____

MEDICARE NO: __ __ __ __ __ __ __ __ __ __ __ REF NO: _____ EXPIRY DATE: ____/ _____

PENSION NO: _____ HEALTHCARE CARD: _____

VETERANS' AFFAIRS (If applicable) _____

PRIVATE HEALTH FUND: _____

MEMBERSHIP NO: _____

REFERRING DOCTOR: _____

LOCAL DOCTOR (If different to referring doctor and you wish correspondence sent to this doctor)

_____ ADDRESS: _____

- **Consultation Fees:** Initial consultation fee is $170 and review consultation fee is $75
- **Operation Fees** will be charged directly to your Private Health Fund. There will be a **Gap Payment** which will be discussed when your operation is confirmed.
- Uninsured patients will be advised of all associated surgical/hospital charges.
- Fees for operation Assistants, Anaesthetists, Pathology and Radiology may not be completely covered by Medicare or Health Funds.

WORKCOVER/TAC CLAIM NO: _____

Date of Accident: _____ Employer: _____

Employer's Address: _____

Contact Person: _____ Phone: _____

Insurance Company: _____ Phone: _____

Privacy Statement:

As part of your medical care, your personal and health related information will be collected. Occasionally information will need to be shared between medical practitioners, hospitals and allied health staff in order to manage your health. De-identification information is also collected for auditing, quality assurance and research purposes. If you do not wish your information to be passed on to other medical practitioners or allied health staff, please bring this up during the consultation. I consent to the collection and disclosure of my information as outlined above.

Signed: _____ Date: _____

Please email this form to admin@melbournegastrosurgery.com

Melbourne Gastro Surgery

CENTRE FOR INTEGRATIVE GUT SURGERY AND WEIGHT MANAGEMENT

Health and Wellbeing Questionnaire

Thank you for taking the time to complete the following questionnaire. This questionnaire will help to establish where your health and wellbeing is currently situated, as well as potential areas of focus for our face to face consulting sessions. The questionnaire is comprehensive, but not exhaustive.

Your answers to this health appraisal questionnaire will assist us in gaining information about your current symptoms and health concerns.

The questions can be answered as Yes or No or with some explanation where required.

We would appreciate it if you can answer all questions, as this will ensure the most accurate interpretation of your results. You may however leave a question blank if you are unsure of the answer.

> *When treating disease it is MORE important to know what sort of person has a disease, than to know what sort of disease a person has.*
>
> *HIPPOCRATES*
> Father of Modern Medicine

Please complete the questionnaire and email it to admin@MelbourneGastroSurgery.com.au

12 Ormond Boulevard
BUNDOORA 3083

Knox Private Hospital
262 Mountain Hwy
WANTIRNA 3152

Jessie McPherson Private Hospital
246 Clayton Road
CLAYTON 3168

Epworth Camberwell
888 Toorak Road
CAMBERWELL 3124

NAME: _____DATE: _____

GENERAL HEALTH QUESTIONS

1. What are your top 3 health issues that prompted you to make an appointment with our practice?

2. How do you rate your general health?

3. Are there any medical conditions for which you take regular medications?

4. Have you had any previous surgery (specifically on the abdomen)?

5. Do you smoke? If yes, how much and for how long?

6. Do you drink? If yes, how much and for how long?

7. Do you get healthy amount and quality of sleep?

8. Do you engage in Regular exercise (at least 3-4 times a week)?

9. How would you rate your diet? Are most of the meals:
    a. Healthy
    b. Moderately Healthy
    c. Mostly fast/junk food

10. What dietary type are you?
    a. Regular meat eater
    b. Occasional meat eater
    c. Vegetarian (no chicken or fish)
    d. Vegan
11. Do you have any allergies,problems with frequent colds ?

12. Do you experience Difficulty focusing - Brain fog?

13. How do you handle Emotional challenges or Stress?

14. Do you experience Poor self image or self esteem leading to depression or anxiety?

15. Do you take time for self care and relaxation ? If Yes, How much per week?

16. Do you maintain a healthy weight? If not what, in your view, is the main reason for this?

17. Do you have any health goals that you want to achieve in the next 12 months? Please list top 3.
    a. _____
    b. _____
    c. _____

GASTROINTESTINAL QUESTIONNARE

(0= Nil symptoms, 1= Mild symptoms,2 = Severe symptoms)

1. Indigestion. 0 1 2
2. Excessive belching, burping. 0 1 2
3. Bloating or fullness commencing during or shortly after a meal. 0 1 2
4. Sensation of food sitting in stomach for a prolonged period after a meal. 0 1 2
5. Bad breath. 0 1 2
6. Loss of appetite, or nausea. 0 1 2
7. History of anaemia or blood loss Yes/No
8. Indigestion or heartburn with spicy or fatty food, citrus, alcohol, or caffeine. Yes / No
9. Heartburn aggravated by lying down or bending forward to waking up from sleep at night with a choking sensation? Yes / No
10. Do you use antacids, carbonated beverages, milk, cream or food relieve the above symptoms. Yes / No
11. Difficulty or pain when swallowing. Yes / No
12. Vomiting blood or vomitus that has appearance of coffee-grounds. Yes / No
13. Abdominal pain, cramping and/or spasms. Yes / No
14. Diarrhoea (loose, watery or frequent bowel movements). Yes / No
15. Constipation (requiring straining, or a hard, dry or small stool). Yes / No
16. Alternating diarrhoea and constipation. Yes / No
17. Sensation of incomplete emptying of bowel. Yes / No

18. Red blood with bowel movement or black tarry stools. Yes / No
19. Rectal pain or cramps. Yes / No
20. Anal itching. Yes / No
21. Fatty foods cause indigestion or nausea. Yes / No
22. Yellowish discolouration of skin or eyes. Yes / No
23. Easy bruising, or bleeding (e.g. of gums). Yes / No
24. Loss or thinning of body hair. Yes / No
25. Skin rashes,acne,dermatitis or eczema. Yes / No
26. Dry, flaky skin, or dry hair. Yes / No
27. Certain foods worsen abdominal symptoms. Yes / No
28. Difficulty gaining or losing weight. Yes / No

Any other information that you would wish to provide,that may have a bearing on your further treatment with us.

_____

_____

_____

_____

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Signed: …… Date: ……..