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

TITLE: Mr FAMILY NAME: _____

GIVEN NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

_____ POSTCODE: _____

TELEPHONE: Home: _____ Work: _____

Mobile: _____ Email: _____

Please Tick to Select: ☐ YES - 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 $220 and review consultation fee is $90
- **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: _____

How did you hear about us: GP ☐ Internet ☐ Friend ☐ Patient ☐ Other

Please email this form to admin@melbournegastrosurgery.com.au

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

Melbourne Gastro Surgery
12 Ormond Boulevard
BUNDOORA 3083

Knox Private Hospital
262 Mountain Hwy
WANTIRNA 3152

Hawthorn East
759 Burwood Road
HAWTHORN 3122

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?

   ☐ Very Fit ☐ Good ☐ Not very 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?

   ☐ Yes ☐ No

6. Do you drink?

   ☐ Yes ☐ No ☐ Heavy Drinker

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

   ☐ Yes ☐ No

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

   ☐ Yes ☐ No

9. How would you rate your diet? Are most of the meals:

   ☐ Healthy

   ☐ Moderately Healthy

   ☐ Mostly fast/junk food

10. What dietary type are you?

- [ ] Regular meat eater
- [ ] Occasional meat eater
- [ ] Vegetarian (no chicken or fish)
- [x] Vegan

11. Do you have an allergy, problems with frequent colds?

☐ Yes ☐ No

12. Do you experience difficulty focusing – Brain fog?

☐ Yes ☐ No

13. How do you handle emotional challenges and stress?

_____

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

(No, Mild, Severe)

1. Indigestion	☐ No	☐ Mild	☐ Severe
2. Excess belching, burping.	☐ No	☐ Mild	☐ Severe
3. Bloating or fullness commencing during or shortly after a meal	☐ No	☐ Mild	☐ Severe
4. Sensation of food sitting in stomach for a prolonged period after a meal.	☐ No	☐ Mild	☐ Severe
5. Bad Breath	☐ No	☐ Mild	☐ Severe

6. History of anaemia or blood loss. ☐ Yes ☐ No

7. Indigestion or heartburn with spicy or fatty food, citrus, alcohol, or caffeine. ☐ Yes ☐ No

8. Heartburn aggravated by lying down or bending forward to waking up from sleep at night with a choking sensation? ☐ Yes ☐ No

9. Difficulty or pain when swallowing. ☐ Yes ☐ No

10. Vomiting blood or vomitus that has appearance of coffee-grounds. ☐ Yes ☐ No

11. Abdominal pain, cramping and/or spasms. ☐ Yes ☐ No

12. Diarrhoea (loose, watery or frequent bowel movements). ◯ Yes ◯ No

13. Constipation (requiring straining, or a hard, dry or small stool) ☐ Yes ☐ No

14. Alternating diarrhoea and constipation. ☐ Yes ☐ No

15. Sensation of incomplete emptying of bowel. ☐ Yes ☐ No

16. Red blood with bowel movement or black tarry stools. ☐ Yes ☐ No

17. Rectal pain or cramps. ☐ Yes ☐ No

18. Anal itching. ☐ Yes ☐ No

19. Fatty foods cause indigestion or nausea. ☐ Yes ☐ No

20. Yellowish discolouration of skin or eyes. ☐ Yes ☐ No

21. Skin rashes, acne, dermatitis or eczema. ☐ Yes ☐ No

22. Difficulty gaining or losing weight. ☐ Yes ☐ No

23. Do you have confirmed diagnosis of obstructive sleep apnoea? ☐ Yes ☐ No

24. Do you snore loudly? ☐ Yes ☐ No

25. Do you often feel tired/fatigued during the daytime? ☐ Yes ☐ No

26. Has anyone observed you stop breathing during your sleep? ☐ Yes ☐ No

27. Do you have or are you being treated for high blood/diabetes/ Heart attack/Angina? ☐ Yes ☐ No

28. Do you have a history of blood clot/deep vein thrombosis/ pulmonary embolism? ☐ Yes ☐ No

29. Are you able to climb more than 1 flight of stairs without stopping? ☐ Yes ☐ No

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 be passed on to other medical practitioners or allied health staff, please bring this up during your consultation. I consent to the in and disclosure of my personal information.

Signature…….. Date……