Upper GI Surgery
A PRACTICE FOR PATIENTS

PATIENT INFORMATION

Please Print

Personal Details

Surname:			First Name:		
DOB:			Age:		
Address:				Postcode:	
Home Phone:			Email:		
Work Phone:			May we use this email to contact you regarding your treatment?		
Mobile:			Yes ☐		No ☐
Occupation:			Religion:		
Marital Status:	Married ☐	Single ☐	Divorced ☐	Widowed ☐	Defacto ☐
Children:					
Are you an Australian Resident:			Yes ☐		No ☐
Country of Birth:			If Australia, specify State:		
Are you of Aboriginal/Torres Strait Islander descent:			Neither ☐ Both ☐		Aboriginal ☐ TSI ☐

Other Contact (Spouse, Partner, Parent, Relative, Friend)

Name:		Relationship:	
Address:			Postcode:
Home Phone:		Mobile:	
Work Phone:		Email:	

Insurance

Medicare Card No:		Ref No:	Exp Date:
Health Fund:		Membership No:	
Pension:		Exp Date:	
Veteran's Affairs No:		DVA Card Colour:	

GP Details

Name:			
Address:			Postcode:
Phone:	Fax:	Email:	

Other Doctors & Specialists

Name:	Address:	Specialty:

Referral Details

How did you hear about us:	
Name of Referring Doctor:	
Reason for Referral:	

MEDICAL HISTORY

Personal History

Have you ever suffered from any of the following?

Illness:	*Yes:*	*Details:*		
Diabetes or Pre-Diabetes (IR)	☐	Type I ☐	Type II ☐	
		When were you diagnosed:		
Asthma	☐			
Respiratory/Breathing Problems	☐			
Sleep Apnoea	☐	Do you use a CPAP device?	Yes ☐	No ☐
Stroke	☐			
Depression	☐			
Gallstones	☐			
Heartburn/Reflux	☐			
Hepatitis/Liver Disease	☐			
High Blood Pressure	☐			
Heart Disease/Angina	☐			
Clotting Disorder/Blood Clot	☐			
PCOS	☐			
Anaemia	☐			
Allergies	☐	Please specify:		
Other	☐	Please specify:		

Other Information

Have you ever smoked?	Yes ☐	No ☐
	How many?	
	How long?	
	If you've stopped, when?	
How many standard alcoholic drinks do you have per week?		

Surgical History

Please detail any past non-bariatric operations, particularly abdominal

Procedure:	*Date:*

Family History

Please detail any illnesses in your immediate family (ie Parents, Siblings)
(eg. Diabetes, heart disease, stroke, high cholesterol/blood pressure, clots)

Medications

Please state all medications that you are taking

Medication:	*Reason for taking:*	*Duration:*

WEIGHT LOSS HISTORY

General Information

How long have you suffered with excess weight?	years
When were you at your heaviest?	
Approximately how heavy were you?	kg
How long have you been seriously trying to lose weight?	years
What is the maximum weight lost by any method?	kg
What was your lightest weight as an adult? When?	

Which of the following have you tried?		**Why do you eat?**	
Dieting	Yes	*Reason*	Yes
Jenny Craig	☐	Love Food	☐
Weight Watchers	☐	Stressed	☐
Sure Slim	☐	Bored	☐
Atkins	☐	Reward	☐
Liquid Diets	☐	Other (please specify):	
Diet Pills			☐
Duramine	☐		☐
Xenical	☐		☐
Reductil	☐		☐

What do you think are the reasons for excessive weight?

No Routine	☐	Grazing	☐
Excessive Food Amounts	☐	Liquid Calories (eg. Alcohol, soft drinks, fruit juice, milk-based drinks)	☐
Bad Food Choices	☐	Other (please specify):	
Boredom Eating	☐		☐
Poor Nutritional Knowledge	☐		☐
Lack of Activity	☐		☐
Love the Taste	☐		☐

Weight Loss Procedure History

Please detail any past bariatric operations

Procedure:	*Date:*

Exercise

Are you doing any regular exercise at the present time?	Yes ☐	No ☐
If yes, what type?		
How many hours per week?		

Testimonial

After your surgery, would you be billing to speak to other patients who are considering surgery?	Yes ☐	No ☐

OFFICE USE ONLY

Height:	Weight:
BMI:	Goal Weight:
Excess Weight:	

Name: