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:*

Name: