Registration Form

Name____ Date ____/____/________

Personal Details

Address: ____

____

____

DOB:______/______/_______ Age: ____________________

Married ☐ Single ☐

Divorced/Separated ☐ Partner/relationship ☐

Email:____

Home Phone: ____

Mobile Phone: ____

Work Phone: ____

Medicare Number: ____

Reference Number:__________Expiry Date:____/____/____________

Private Health Fund Yes No

Fund Name: ____

Number:____

Reference Number: ____

Emergency Contact

Name: ____

Phone:____

Relationship: ____

Referring Doctor

Usual GP Name: ____

____

____

Address: ____

____

Phone: ____

Occupation: ____

Medical History Do you have any of the following medical problems?

	Yes	No		Yes	No		Yes	No
Diabetes	☐	☐	Diabetes of pregnancy	☐	☐	Arthritis	☐	☐
On Insulin	☐	☐	Are you pregnant?	☐	☐	Back Problems	☐	☐
Heart Disease	☐	☐	High Blood Pressure	☐	☐	Other operations, admissions to hospital or psychological issues:		
Sleep Apnoea	☐	☐	High Cholesterol/Lipids	☐	☐			
Lung Disease eg asthma	☐	☐	Epilepsy	☐	☐			
Liver Disease eg hepatitis	☐	☐	Stroke/mini Stroke	☐	☐			
Gastric Band Surgery	☐	☐	Kidney Disease	☐	☐	Other Problems:		
Stomach Surgery	☐	☐	Pacemaker/ICD	☐	☐			
Reflux Disease	☐	☐	Thyroid Problems	☐	☐			
Stomach Ulcers	☐	☐	Clots in the leg/lung	☐	☐			
Smoker Current	☐	☐	Smoker in the past	☐	☐			
Infertility/PCOS	☐	☐	Depression/Anxiety	☐	☐			

Medication **Please list your current medication, including non-prescribed medication, doses are not required.**

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Weight Loss Surgery Patients ONLY

Weight History

Please indicate your weight history by ticking the appropriate box:

	Below average	Average	Above average	Very heavy
Primary school	☐	☐	☐	☐
Secondary school	☐	☐	☐	☐
Commencing work	☐	☐	☐	☐
At time of marriage (if applicable)	☐	☐	☐	☐

Do you know anyone else who has had obesity surgery? Yes ☐ No ☐

Alcohol Intake

Please estimate your alcohol intake per week: ____________________

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Use the following scale to choose the most appropriate number from 0-3 for each situation.

0 = no chance of dozing | **1 = slight chance of dozing** | **2 = moderate chance of dozing** | **3 = high chance of dozing**

Situation	Chance of Dozing			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (eg. Theatre or meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Exercise History

Are you currently exercising regularly? Yes No

What sort of Exercise do you enjoy doing?

Are you able to run up a single flight of stairs without getting short of breath? Yes No

Preferred weight loss operation?

- ◯ Sleeve Gastrectomy
- ◯ Gastric Bypass
- ◯ Gastric Band
- ◯ Orbera Balloon
- ◯ Revision Surgery
- ◯ Loop Duodenal Switch (SIPS/SADI)

Where did you hear about us?

- ◯ Word of Mouth
- ◯ General Practitioner / Specialist
- ◯ Google Search Engine
- ◯ Social Media Platform
- ◯ Other:

Permission:

Please give permission for the information you provide in this questionnaire to be distributed for use by the surgeon, dietician, anaesthetist and physician during your weight loss surgery programme:

Signature: ______________________ Date: ______________

PATIENT CONSENT FORM

We require your consent to collect personal information about you. Please read this information carefully and sign where indicated below.

The medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means we will use the information in the following ways:

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- Disclosure to other doctors in practice, locums and by Registrars attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records accessed for these purposes, and we will note your record accordingly.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management.
- Bariatric Surgery Only ;
  - As a requirement for ongoing accreditation with ANZMOSS (Australia & New Zealand Metabolic & Obesity Surgery Society) it is necessary to contribute data to a national registry (de-identified data only) of Bariatric Surgery
  - All procedures may be recorded

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling the patient information. I understand that I am not obliged to provide any information requested of me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances. I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by the practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.

Signed____(Patient) Date:______/______/__________

Mr Anthony Clough MBBS FRACS **Grad Cert**

General, Upper GI, & Obesity Surgeon

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