



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

PATIENT REGISTRATION FORM

TITLE: _____ 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 \$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: _____

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

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



Melbourne Gastro Surgery
12 Ormond Boulevard
BUNDOORA 3083

Knox Private Hospital
262 Mountain Hwy
WANTIRNA 3152

Jessie McPherson Private Hospital
246 Clayton Road
CLAYTON 3168

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)

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 QUESTIONNAIRE

(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

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Signature..... Date.....