



Attending Surgeon: Dr William Braun
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NEW PATIENT INFORMATION SHEET

All fees are requested at the time of consultation unless paid prior to consultation.

Title: _____ **First Name:** _____ **Surname:** _____

Prefer to be called: _____ **Marital Status:** _____

Address: _____

Suburb: _____ **State:** _____ **Post Code:** _____

Date of Birth: _____ **Age:** _____ **Sex:** Male / Female (Please circle)

Home Phone: _____ **Work Phone:** _____ **Mobile:** _____

Occupation: _____

Email address: _____

Medicare No: _____ **Reference No.** _____ **Card Expiry:** _____
(No. next to your name on your card)

Dept Veteran Affairs No: _____ **Do you have private health insurance?** Y / N

Private Health Fund: _____ **Membership No.** _____

Referring Dr: _____

Practice Name and Address: _____ **Phone:** _____

NOK/Emergency Contact: _____ **NOK Phone:** _____

Relationship to patient: _____

Correspondence will be sent to your referring Doctor. Do you agree to this? Y / N

Are you a Diabetic? Y/N



PERSONAL HISTORY

OFFICE USE ONLY				
Date	Weight (kg)	Height (cms)	BMI	Excess

MEDICAL HISTORY

Weight related Medical Conditions: Do you have any of the following conditions?

High blood pressure	<input type="radio"/> Yes	<input type="radio"/> No	High cholesterol	<input type="radio"/> Yes	<input type="radio"/> No
Angina (cardiac chest pain)	<input type="radio"/> Yes	<input type="radio"/> No	Infertility	<input type="radio"/> Yes	<input type="radio"/> No
Weight bearing joint pain	<input type="radio"/> Yes	<input type="radio"/> No	Polycystic Ovary Syndrome	<input type="radio"/> Yes	<input type="radio"/> No
Which joints? _____			Do you have insulin resistance	<input type="radio"/> Yes	<input type="radio"/> No
Diabetes 2	<input type="radio"/> Yes	<input type="radio"/> No	Fatty Liver	<input type="radio"/> Yes	<input type="radio"/> No
If yes, how long have you had Diabetes?				<input type="radio"/> Not known	
What treatment is used to control your Diabetes?					
Tablet controlled	<input type="radio"/>				
Diet controlled	<input type="radio"/>				
Is insulin required	<input type="radio"/>				
Gallstones	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not known	Chronic heartburn or reflux	<input type="radio"/> Yes
					<input type="radio"/> No
Have you had your gallbladder removed?				<input type="radio"/> Yes	<input type="radio"/> No
Do you have a hiatus hernia? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure					
Depression				<input type="radio"/> Yes	<input type="radio"/> No
Have you noticed improvement when you lose weight?				<input type="radio"/> Yes	<input type="radio"/> No
Do you have sleep apnea?				<input type="radio"/> Yes	<input type="radio"/> No
Has this been confirmed with a sleep study?				<input type="radio"/> Yes	<input type="radio"/> No
Do you use CPAP?				<input type="radio"/> Yes	<input type="radio"/> No

How does your weight affect your quality of life?

*Please circle - (not at all) 2 (mildly) 3 (moderately) 4 (significantly) 5 (excessively)

Sleep	1	2	3	4	5
Energy	1	2	3	4	5
Perspiration	1	2	3	4	5
Self Esteem	1	2	3	4	5
Confidence	1	2	3	4	5
Relationships	1	2	3	4	5
Occupational limitations	1	2	3	4	5
Urinary Incontinence	1	2	3	4	5
Avoid being photographed	1	2	3	4	5
Avoid social events	1	2	3	4	5
Avoid swimming in public	1	2	3	4	5

FAMILY HISTORY (Blood relatives)

Do you have a family history of any of the following?

Obesity	<input type="checkbox"/>	Which family member/s?
Diabetes	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	
Cancer - Which type?	<input type="checkbox"/>	

Past Abdominal Surgery (Please indicate if done laparoscopically or open)

Gallbladder removal?	<input type="radio"/> Yes	<input type="radio"/> No
Removal of appendix?	<input type="radio"/> Yes	<input type="radio"/> No
Colon Surgery?	<input type="radio"/> Yes	<input type="radio"/> No

Any other medical problems?

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Current Medications – Please list below

Name of drug	
1.	4.
2.	5.
3.	6.

Allergies	1.	2.
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Have you attended an information seminar? Yes No
If so where? Clinic: Other:

Do you have a friend or relative that has had weight loss surgery? Yes No
If so which type? Gastric Lapband: Sleeve gastrectomy: Other:

How have you gone about researching weight loss surgery?

Internet: **Which site/s?** _____
Newspaper: **TV:**
Other: **Magazine:**

How long have you been seriously thinking about considering weight loss surgery? _____



PRIVACY CONSENT

The Privacy Act 1988, as amended by The Privacy Amendment (Privacy Sector) Act 2000, requires medical practitioners to obtain consent from their patients to collect, use and disclose patient's personal information. Please read this information carefully and sign where indicated below.

We require you to provide us with your personal details and a full medical history so that you can be properly assessed and treated. The information supplied will be used in the following ways:

Administrative and billing purposes in running the medical practice, including treating doctors, specialists and physiotherapists 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.

Both our practice staff and specialists may participate in the collection of this information.

In emergency situations we may need to collect personal information from relatives or other sources where we are unable to obtain your prior express consent.

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 patient information.

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 that I will be given an explanation in these circumstances. *(It is likely that you will be asked to contribute to the cost of providing this information)*

I understand that if my information is to be used for any purpose other than set out above, my further consent will be obtained.

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

Signed: _____ Print Name: _____



SURGEON'S USE ONLY							
Discussed risks, benefits & alternatives in relation to:	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">LAGB</td> <td style="text-align: right;"><input type="checkbox"/></td> </tr> <tr> <td>LSG</td> <td style="text-align: right;"><input type="checkbox"/></td> </tr> <tr> <td>ORBERA Balloon</td> <td style="text-align: right;"><input type="checkbox"/></td> </tr> </table>	LAGB	<input type="checkbox"/>	LSG	<input type="checkbox"/>	ORBERA Balloon	<input type="checkbox"/>
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Consent:	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">Financial</td> <td style="text-align: right;"><input type="checkbox"/></td> </tr> <tr> <td>Clinical</td> <td style="text-align: right;"><input type="checkbox"/></td> </tr> </table>	Financial	<input type="checkbox"/>	Clinical	<input type="checkbox"/>		
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Optifast:	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">2 weeks</td> <td style="text-align: right;"><input type="checkbox"/></td> </tr> <tr> <td>Other</td> <td style="text-align: right;"><input type="checkbox"/></td> </tr> <tr> <td>Reason: _____</td> <td></td> </tr> </table>	2 weeks	<input type="checkbox"/>	Other	<input type="checkbox"/>	Reason: _____	
2 weeks	<input type="checkbox"/>						
Other	<input type="checkbox"/>						
Reason: _____							
Referred to:	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">Dietician</td> <td style="text-align: right;"><input type="checkbox"/></td> </tr> <tr> <td>Psychologist</td> <td style="text-align: right;"><input type="checkbox"/></td> </tr> </table>	Dietician	<input type="checkbox"/>	Psychologist	<input type="checkbox"/>		
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Surgery scheduled for: Date: _____	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">SAN</td> <td style="text-align: right;"><input type="checkbox"/></td> </tr> <tr> <td>Mater</td> <td style="text-align: right;"><input type="checkbox"/></td> </tr> <tr> <td>Concord</td> <td style="text-align: right;"><input type="checkbox"/></td> </tr> </table>	SAN	<input type="checkbox"/>	Mater	<input type="checkbox"/>	Concord	<input type="checkbox"/>
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