Mr Ramez Bassari BHB, MBChB, FRACS ANZGOSA
Bariatric, Upper GI, Laparoscopic and General Surgeon. Endoscopist.
Epworth Hospital
Danks Wing, Level 6
Suite 6.5, 89 Bridge Rd
Richmond Vic 3121
T: 9429 1002
F: 8672 0771

New Patient Registration

Title: _________ First Name: _____________________ Surname:_____________________________

Preferred Name: ________________________ DOB: _____/_____/_____ Male ______ Female _____

Address: ____

Home Phone:__________________________ Mobile:_______________________________________

Occupation: ___________________________ Email: _______________________________________

Local Doctor (GP) & Name of Clinic: ____

Address: ____

Referring Doctor (*if different)* ____

Address: ____

Next of Kin: ____________________________ Phone: _________________ Relation: _____________

Medicare No: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Ref No: _____ Exp Date: _____ / _____

Private Hospital Insurance: YES / NO If YES; longer than 12 months YES / NO

Fund Name: ____ Number: ____________________

Veterans Affairs (DVA) Number: _____________________________________ GOLD / WHITE

Do you take any **Blood Thinning medications**: YES / NO (List name & dose of medication on next page)

Motor Accident ? -TAC Number: __________________________ Date of Accident: _________________

Workcover: Name of Employer: ____

Address of Employer: ____

Telephone Number: _____________________________ Claim No: ___________________________

Name & Address of Insurance Company: ____

Have you enclosed your referral letter? YES / NO If no, why? ______________________________

I give my consent for Mr Ramez Bassari to use my information to communicate with other health professionals. I also give consent to Mr Ramez Bassari obtaining relevant information about myself from other health professionals. Mr Bassari may order investigations with Radiology/Imaging such as; MRI, MRCP, CT, ultrasound scans & pathology. These investigations may/will incur fees and you should ask at the time of booking what the cost to you will be.

Signed: ____ **Date:** _____ / ______ / ______

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Patient Health Survey: Name: ____

DOB: _____/_____/_____

Main diagnosis/symptoms (brief): ____

____

____

Duration of problem/symptoms: ____

Past medical/surgical problems: ____

____

____

____

Medications: *(prescribed and non prescribed) OR (attach a list)*

Name	Dose	Name	Dose

Allergies: *(medicines/tapes/antiseptics/foods/latex/rubber)*

____

____

Smoking History: Non-Smoker _____ Ex-Smoker _____ Duration? _______________ Smoker _____
Details *(current or previous)*: Duration of smoking: __________________ Cigarettes / day: ____________

Alcohol – standard drinks / week: ____
Recreational drugs No _____ Yes _____ ___________________________________

Hearing impairment No _____ Yes _____ ___________________________________
Visual impairment No _____ Yes _____ ___________________________________
Mobility impairment No _____ Yes _____ Stick / Frame / Crutches / Wheelchair
High blood pressure No _____ Yes _____ ___________________________________
High cholesterol No _____ Yes _____ ___________________________________
Are you pregnant? No _____ Yes _____ Are you breast feeding? Yes _____ No _____

Weight: ______________ kg Height: ______________ cm

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General Medical Conditions *(current and previous)*
Please tick any conditions/symptoms you have and provide details

Heart

Heart attack _____ Angina _____ Heart surgery/Coronary stent _____ Palpitations _____ Pacemaker _____

Details: ____________________

Lungs/Breathing

Asthma _____ Bronchitis _____ Emphysema _____ Pneumonia _____ Tuberculosis _____

Sleep problems/apnoea _____ Walking up one flight of stairs causes breathing difficulties ___________

Details: ____________________

Gastrointestinal

Crohn's _____ Ulcerative colitis _____ Coeliac's disease _____ Peptic ulcers _____ Gallstones ____

Hepatitis _____ Diarrhoea _____ Constipation _____ Recent change of bowel habit _____

Rectal bleeding _____ Nausea _____ Vomiting _____ Vomiting blood _____ Weight loss _____

Loss of appetitie _____

Details: ____________________

Endocrine

Diabetes _____ Type 1 / 2 Control: Diet / Tablets / Insulin Thyroid problems ______

Details: ____________________

Neurological

Strokes/Mini-strokes _____ Epilepsy/Fits _____ Multiple sclerosis _____

Details: ____________________

Kidney/Prostate

Kidney stones _____ Dialysis _____ Prostate difficulties _____

Details: ____________________

Blood disorders

Anaemia _____ Bleeding disorders _____ Clotting abnormalities _____ Blood transfusions _____

Details: ____________________

Cancer No _____ Yes _____ If yes; where? ____________________

Date of diagnosis: ____ / ____ / ____ Treatment: Surgery ___ Chemotherapy ____ Radiotherapy ____

Details: ____________________

Please list any other medical conditions or symptoms you have *(use a separate page if necessary)*:

____

Signed: ____________________ Date: _____ / _____ / _____