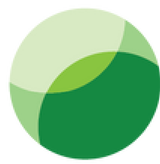

Associate Professor
Christos Apostolou

Robotic Upper Gastrointestinal, Pancreatic & General Surgeon

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

PATIENT INFORMATION

Given Names: ______________________ Last Name: ______________________

Date Of Birth: ______________ Age: ______________

Address: ____

Suburb: ______________ State: ______________ Post code: ______________

Email: ______________________ Mobile Number: ______________________

Home Number: ______________________ Work Number: ______________________

Next Of Kin: ______________________ Phone: ______________________

Referring Doctor: ______________________ Cardiologist Name: ______________________

Usual GP & Suburb: ____

PERSONAL HEALTH INFORMATION

Are you taking blood thinners?: ◯ Yes ◯ No If yes, which? ______________________

Previous Abdominal Surgery: ____

Allergies: ____

Medications: ____

INSURANCE INFORMATION

Veterans Affairs No: ______________________ Expiry Date: ______________________

Pension Number: ______________________ Expiry Date: ______________________

Private Health Fund: ______________________ Membership Number: ______________________

Medicare Number: ____

Your Place on the Card: ______________________ Expiry Date: ______________________

PRIVACY NOTE

I agree to allow the doctors and staff at this practice to access all relevant information regarding my medical conditions. I agree that the doctors and staff may be required to forward/obtain information about my medical condition/history from my referring doctor or other health care providers. I understand that my clinical records may be accessed or reviewed by staff at this practice.

CONSENT

Clinical photographs will be taken as part of my consultation and procedures, my clinical photographs may be used for medical educational purposes (doctors/nurses/medical students only). Details of my consultation can be used in communication with other health care professionals who are involved in my care. Additionally, I give my permission for my clinical photographs to be used for public education purposes.

I DECLARE THAT TO THE BEST OF MY KNOWLEDGE THE INFORMATION I HAVE PROVIDED ON THIS FORM IS ACCURATE

Patient Signature:

____

If signed by a Parent/Guardian please complete: Date:

______________________ ______________