Dr. Jason Maani

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Patient Form

□Mr □Miss □Mrs □Ms		
Name:	D.O.B:	
Address:		
Suburb:	Postcode:	
Mobile Number:		
Medicare Number:	Ref:	Exp:
Private Health Fund Name:	Membership Number:	
DVA Number:	Card Type:	
Pension Card Number:	Exp:	
Occupation:		
Next of Kin Name:	Number:	Relationship:
Are you wanting to access your super: □Yes □No		

Cultural Background
Country of Birth:_____ □Aboriginal □Torres Strait Islander □Both □Neither

Medical History		
□ High Blood Pressure	□ Heart Disease	□ Diabetes (□ Type 1 □ Type 2)
□ Sleep Apnoea	□ Gallstones	□ Asthma/Respiratory Issues
□ Reflux/Heartburn	□ Depression/Mental Health Issues	□ Anaemia
□ Liver Disease/Hepatitis	□ Blood Clots/Clotting Disorder	□ PCOS
□ Other (please specify): _____ _____		
Do you have allergies: □ Yes □ No If yes – please list: _____ _____		

Current Medications		
Medication	Reason	Duration

Surgical History

Previous surgeries (including weight loss surgery)? □ Yes □ No

If yes, please list:

_____

_____

_____

Blood transfusion in the past: □ Yes □No

If yes, what year: _____

Lifestyle	
Do you smoke:	□ Yes □ No If yes, how many per day? _____
Do you drink alcohol:	□ Yes □ No If yes, how often? _____
Are you currently exercising:	□ Yes □ No

Referral & Background

How did you hear about us: □GP referral □Friend/Family □Google Search □Facebook □Google Reviews □ Other: _____

For Bariatric Patients – If Applicable		
Current Measurements:	Height: _____ cm	Weight: _____ kg
How long have you struggled with excess weight?	_____ years	
Heaviest weight?	_____ kg – when? _____	
Lightest weight?	_____ kg – when? _____	
Attempts at weight loss (tick)	□ Diet Programs □ Medications □ Other: _____	
Main factors affecting weight management:	□ Routine □ Emotional eating □ Injury □ Genetics □ Other: _____	

Consent & Privacy

I understand that my personal and medical information is collected for the purpose of providing quality healthcare. I consent to the use and sharing of my information as required for my treatment, in line with the clinic's Privacy Policy.

Name:	**Signature:**	**Date:**