New Patient Registration and Health Form

Please complete this form before your first consultation and bring it with you, or return it to Dr Kumar's team. If you have been sent a link by text message, you can complete the same form online instead.

> Everything you write here is confidential and is used only for your care. If you are unsure about a question, leave it and Dr Kumar's team will go through it with you.

About you

TITLE

PREFERRED NAME

FIRST NAME

SURNAME

DATE OF BIRTH

SEX / GENDER

OCCUPATION

STREET ADDRESS

SUBURB / TOWN

STATE

POSTCODE

MOBILE

OTHER PHONE

EMAIL

PREFERRED LANGUAGE

INTERPRETER NEEDED

☐ No ☐ Yes

Emergency contact

NAME

RELATIONSHIP

PHONE

Referral and your doctors

A current GP referral addressed to Dr Rohit Kumar is needed for every patient.

GP NAME

PRACTICE

PHONE

REFERRING DOCTOR (IF NOT YOUR GP)

DATE OF REFERRAL

☐ Please send letters about my care to my GP ☐ Please do not send letters to my GP

Medicare and health fund

MEDICARE NUMBER

POSITION ON CARD

EXPIRY

HEALTH FUND

MEMBERSHIP NUMBER

LEVEL OF HOSPITAL COVER

DVA OR PENSION CARD NUMBER (IF ANY)

DATE YOU JOINED OR LAST UPGRADED YOUR FUND

What you would like to discuss

- ☐ Abdomen
- ☐ Body lift (abdomen, flanks, back and buttocks)
- ☐ Arms
- ☐ Thighs
- ☐ Breasts
- ☐ Male chest
- ☐ Back
- ☐ Mons pubis
- ☐ Breast implants (removal or revision)
- ☐ Scars or skin lesion
- ☐ Other

IN YOUR OWN WORDS, WHAT CONCERNS YOU MOST?

HOW DID YOU HEAR ABOUT DR KUMAR? (OPTIONAL)

Weight history

Please complete this section if you have lost a significant amount of weight.

HEIGHT (CM)

CURRENT WEIGHT (KG)

HIGHEST WEIGHT (KG)

YEAR OF HIGHEST WEIGHT

DATE YOUR WEIGHT BECAME STABLE (WITHIN ABOUT 3 KG)

LOWEST WEIGHT SINCE (KG)

How did you lose weight?

- ☐ Diet and exercise
- ☐ Gastric sleeve
- ☐ Gastric bypass
- ☐ Gastric band
- ☐ Other weight-loss surgery
- ☐ Weight-loss injections (GLP-1 medicine)

OPERATION NAME, DATE AND SURGEON (IF ANY)

WEIGHT-LOSS MEDICINE: NAME, DOSE, START DATE, STILL TAKING?

Problems caused by excess skin

- ☐ Rashes or skin infections in skin folds
- ☐ Difficulty with hygiene
- ☐ Difficulty exercising or walking
- ☐ Back, neck or shoulder pain
- ☐ Clothing does not fit
- ☐ Other

TREATMENT YOU HAVE TRIED FOR RASHES OR INFECTIONS, AND FOR HOW LONG

Your health

Please tick any that apply to you, now or in the past.

- ☐ Diabetes
- ☐ High blood pressure
- ☐ Heart disease or irregular heartbeat
- ☐ Blood clot (DVT or PE)
- ☐ Bleeding or clotting disorder
- ☐ Asthma or lung disease
- ☐ Sleep apnoea / CPAP
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Thyroid disease
- ☐ Autoimmune or connective tissue disease
- ☐ Anaemia or low iron
- ☐ Cancer
- ☐ Keloid or thickened scars

☐ Depression, anxiety or other mental health condition

☐ Eating disorder

☐ Epilepsy or seizures

☐ Hepatitis or HIV

☐ Reflux

☐ Previous problems with an anaesthetic

DETAILS OF ANYTHING TICKED

MEDICINES

Include prescription medicines, blood thinners, weight-loss injections, contraceptives, vitamins, supplements and herbal remedies.

Medicine	Dose	What it is for

ALLERGIES (MEDICINES, DRESSINGS, TAPE, LATEX) AND THE REACTION

PREVIOUS OPERATIONS

OPERATION AND YEAR

OPERATION AND YEAR

OPERATION AND YEAR

BREAST IMPLANTS: BRAND, SIZE AND YEAR (IF ANY)

LIFESTYLE

NICOTINE (SMOKING, VAPING, PATCHES, GUM)

☐ Never ☐ Stopped (date _____) ☐ Current

ALCOHOL (STANDARD DRINKS PER WEEK)

ARE YOU PREGNANT, BREASTFEEDING, OR PLANNING A PREGNANCY?

☐ No ☐ Yes (details) _____

DO YOU CARE FOR YOUNG CHILDREN AT HOME?

☐ No ☐ Yes

Privacy and photographs

Dr Kumar's practice collects your personal and health information to provide your care, to communicate with your doctors, hospital and health fund, and to process Medicare and fund claims. It is stored securely and handled under the Australian Privacy Principles. You can ask to see your information at any time.

Clinical photographs are part of your medical record and are needed to plan your surgery. They are never used for anything else without your separate consent below, which you can change at any time.

I consent to my clinical photographs being used, without my name, for:

☐ Teaching other health professionals ☐ Medical publications ☐ Patient education, including Dr Kumar's website ☐ None of these

I confirm that the information on this form is correct to the best of my knowledge, and I agree to tell Dr Kumar's team if anything changes.

SIGNATURE

DATE

> Return this form to Dr Kumar's team by email to info@drkumar.com.au, or bring it to your consultation. Questions: 1300 267 726.