# Patient Information Form

## Patient Details

Family name: _____ Given names: _____

Preferred name: _____ Gender: _____ Pronouns: _____ DOB: _____

Ethnicity: _____ If other, please specify _____

Address:

_____

Postal address: ☐ Same as above

_____

Home no: _____ Mobile no: _____

Email: _____

Do you give permission for this email/phone number to be used to contact you regarding your treatment/ appointments/recalls: ☐ **Yes** ☐ **No**

## Personal Contact

(Person that you give us permission to communicate with):

Name: _____ Relationship: _____

Address:

_____

Home no: _____ Mobile no: _____

Email: _____

## Regular GP Details

Name: _____

Practice address: _____

Phone: _____ Fax: _____

Email: _____

## Other Doctors and Specialists

| Name: | Practice Address: | Specialty: |
|---|---|---|
| | | |
| | | |
| | | |

## Insurance

Medicare no: _____ Patient ref no: _____ Expiry: _____

DVA no: _____ Type: _____ Expiry: _____

Private Health Insurance: ☐ **Yes** ☐ **No**

Membership no: _____ Insurer: _____

## Concession

Concession card no: _____

Expiry: _____

Concession card type: _____



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## Medical History

| Illness: | Details: |
|---|---|
| ☐ Diabetes/pre-diabetes/insulin resistance | |
| ☐ Gestational diabetes | |
| ☐ Polycystic ovary syndrome | |
| ☐ Fertility issues | |
| ☐ Gynaecological/menstrual issues | |
| ☐ Thyroid issues | |
| ☐ High blood pressure | |
| ☐ Heart disease/angina | |
| ☐ Atrial fibrillation | |
| ☐ High cholesterol | |
| ☐ Liver disease | |
| ☐ Gallbladder issues | |
| ☐ Joint/mobility issues/arthritis | |
| ☐ Sleep apnoea<br>Do you use a CPAP device: ☐ Yes ☐ No | |
| ☐ Asthma/other respiratory issues | |
| ☐ Reflux | |
| ☐ Clotting disorder/blood clots | |
| ☐ Depression/anxiety | |
| ☐ Other mental health history | |
| ☐ Other medical history | |

## Surgical History

Please detail any past non-bariatric operations, particularly abdominal

| Procedure: | Date: |
|---|---|
| | |
| | |
| | |

## Weight Loss Procedures

Have you previously had any type of bariatric surgery
or endoscopic procedure for weight loss? ☐ **Yes** ☐ **No**

| Procedure: | Date: |
|---|---|
| | |
| | |
| | |

## Family History

Please detail any illnesses in your immediate family (i.e. parents, siblings) e.g. diabetes, heart disease, stroke, high cholesterol, blood pressure, clots.

| Disease: | Relationship to member: |
|---|---|
| | |
| | |
| | |

## Medications

Please state all medications that you are taking

| Medication: | Dose: | Reason for taking: | Duration: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| Supplements: |
|---|
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| |
| |
| |

## Smoking History

Do you smoke? ☐ **Yes** ☐ **No** ☐ **Ex-smoker** quit in year: _____

## Alcohol History

On average how many standard drinks do you have per week? _____

How many nights per week do you drink? _____

## Allergies

| Allergy: | Nature of reaction: |
|---|---|
| | |
| | |
| | |

## General Weight Loss History

What has been your heaviest (non-pregnant) weight? _____ When? _____

What has been your lightest adult weight? _____ When? _____

At what weight have you felt most comfortable? _____

What is the maximum amount of weight you have been able to lose by any method? _____

When? _____ What method? _____

## Weight Loss Attempts

Which of the following have you tried?

☐ Diets: (Please specify) _____

☐ Meal replacements/shakes

☐ Weight loss medications: (Please specify)

☐ Reductil ☐ Duromine ☐ Xenical

☐ Contrave ☐ Saxenda ☐ Other

☐ Exercise programs: (Please specify)

_____

_____

## Eating Behaviours

Do you have regular meals? ☐ **Yes** ☐ **No**

Do you frequently skip meals? ☐ **Yes** ☐ **No**

Do you graze during the day? ☐ **Yes** ☐ **No**

Do you get up at night to eat? ☐ **Yes** ☐ **No**

Do you think you binge eat? ☐ **Yes** ☐ **No**

Do you consume liquid calories in excess
eg alcohol, soft drink, juices, milk drinks, cordial? Please specify ☐ **Yes** ☐ **No**

_____

Do you feel there is an issue with quantity or quality of food? ☐ **Yes** ☐ **No**

Please specify: ☐ **Quantity** ☐ **Quality**

How often do you have take-away meals/fast food per week? _____

Are you always hungry? ☐ **Yes** ☐ **No**

Do you crave food? ☐ **Yes** ☐ **No**

Please specify: _____

What are the eating behaviours that you would most like to change?

_____

_____

## Referral Details

How did you hear about Re:You: _____

Who has referred you: _____

Have you seen a bariatric surgeon: ☐ **Yes** ☐ **No**

*If yes*, what is their name: _____

## Activity Levels

Do you engage in any form of structured physical activity? ☐ **Yes** ☐ **No**

| **Type of exercise:** | **Duration (per week):** |
|---|---|
| | |
| | |
| | |

## Reason For Seeking Help

Think about what is your WHY? Why do you want to lose weight? What are the most important reasons to you?

_____

_____

**Please follow the link to view our Privacy Statement :** https://reyouhealth.com.au/reyou-privacy-statement/

**I certify** that I have read and understood the Re:You Privacy Statement on their website and consent to my personal information being collected, stored, used, disclosed and accessed as outlined in that Statement.

I understand that I am not obligated to provide any information requested of me, but that a failure to do so may compromise the quality of care and treatment provided.

I authorise Re:You to send text messages for appointment, recall and/or payment reminders and information via email from time to time.

I have reviewed Re:You's fees outline on their website, and I accept responsibility for any accounts arising from Re:You services. I am aware that I can contact Re:You to clarify any questions concerning fees.

I understand that for consultations that do not attract a private fee, I agree for the benefit to be assigned to Medicare.

**Name:** _____

**Signed:** _____

Use a digital signature if you have one, otherwise please initial and we will get your signature during your first appointment. **Initial:** _____

**Date:** _____