Mr Adam Skidmore
Upper GI, General & Bariatric Surgeon

Patient Details

Personal Details

Title: _____ Surname: ________________________ Given name: ____________________________________

Address: ____

Suburb: ____________________________________ Postcode: _ _ _ _

DOB: ___ / ___ / ________

Mobile: _ _ _ _ _ _ _ _ _ _ Home Phone: _ _ _ _ _ _ _ _ _ _

Email: ______________________________________ Work Phone: _ _ _ _ _ _ _ _ _ _

Medicare/Health fund

Medicare Number: _ _ _ _ _ _ _ _ _ _ Patient Ref No: _ Expiry: _ _ / _ _ _ _

Hospital Fund: ______________________________ Membership Number: ___________________________

Level of Cover: ______________________________ Have you served waiting period: ________________

DVA: Status: ________________________________ Number: ____

If this is a Work Cover/TAC Claim please provide details: ____

____

Next of Kin

Surname: __________________________________ Given Name: _____________________________________

Contact number: ____________________________ Relationship: ____________________________________

Medical History

Are you a current smoker? If yes, how many do you smoke a day?	☐ Yes	☐ No
Are you a past smoker? If yes, when did you cease?	☐ Yes	☐ No
Do you drink alcohol? If yes, volume: Frequency:	☐ Yes	☐ No
Are you Diabetic? If yes, details:	☐ Yes	☐ No
Do you have a pace maker or internal defibrillator? Details:	☐ Yes	☐ No
Other relevant medical history:		

Allergies

Please list all allergies:

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Current Medications

The medications that you are on may affect the outcome of any upcoming surgery.

Please complete this form so that your medications, including herbal medications, can be assessed. If required, you will be advised of medication you will need to cease prior to surgery. In some cases, an alternative medication will be organized.

If you are on no medications, please write NA.

Name (please print): ___________________________________

Signature: _________________________ **Date:** ___/___/____

MEDICATION NAME	DOSAGE

2022-1