PATIENT REGISTRATION FORM

Miss/Ms/Mrs	Surname	First name	Date of birth
Home address		PO Box (if applicable)	
Street		PO	
Suburb		Suburb	
Postcode		Postcode	
Home phone		Mobile phone	
Email address			
Occupation			
Medicare number	Reference number (left of name)	Expiry date	
Private health fund	Membership number	Type of cover HOSPITAL/EXTRAS/BOTH	
DVA file number		Gold card/White card/Other (please specify)	
Pension/HCC number		Type of pension	
GP name		GP's Clinic	
GP Suburb		GP's Telephone number	
Emergency contact (Next of Kin) Name Relationship		Telephone number	

Would you like SMS appointment reminders? YES NO

Would you like email appointment reminders? YES NO

How did you hear about us? _____

In your own words, why are you seeing Professor Obermair? _____

_____

_____

PRIVACY CONSENT

The provision of quality health care requires a doctor-patient relationship of trust and confidentiality. Consistent with our commitment to quality care this practice has developed a policy to protect patient privacy in compliance with private legislation.

It may be necessary for us to collect personal and sensitive information from patients and sometimes others associated with their health care in order to attend to their needs and for administrative purposes.

In the interests of the highest quality and continuity of the patient's health care this may also include sharing information with other health care providers who comprise a patient's medical team from time to time.

If you have been diagnosed with cancer or pre-cancer your case may be discussed at a multidisciplinary team meeting with the aim of enhancing the effectiveness and safety of your care. At this meeting histopathological test results as well as medical imaging, your care and treatment may be discussed with other health professionals including but not limited to pathologists, specialist nurses, radiologists, radiotherapists, medical oncologists and specialist trainees.

This practice will also send communications (hard copy and electronic letters) to all relevant health care providers (your referring doctor, your GP, other specialists) detailing the diagnosis and treatment provided. Any person to whom your personal or health information is disclosed is required to keep that information confidential by law.

We utilize a note taking tool called "Heidi" to accurately and efficiently capture the details of our discussions and the outcomes of our appointments with patients. It helps us to focus our efforts more on our conversation and less on note taking.

Research is regularly carried out by medical specialists to assist in developing better treatment/cures for diseases. Prof. Obermair is a full member of the Queensland Centre for Gynaecological Cancer, which may store and process data relating to your condition/treatment for research and education purposes (note: this information will be kept anonymous at all times).

In addition, Prof. Obermair will use your anonymous data about treatment outcomes in quality assurance programs to self-audit and further improve his surgical performance.

Photos and/or videos may be taken from your medical condition or from surgery and used in a de-identified way (you will not be recognisable) for medical training purposes to medical and nursing staff. Dr Obermair alone will have access to these images, which are stored electronically on his phone and on his computer (both password protected).

I, _____, have read the above information and give my consent to the above.

Signed: _____ Date: ___ / ___ / ___

MEDICATION LIST

Patient's Name: _____ Date of Birth: ___/___/___

Prior to your surgery, it is extremely important that we are aware of all medication you are currently taking, especially any that may thin out your blood. To help us gather this information, please answer the following questions.

DO YOU TAKE ANY PRESCRIPTION MEDICATION? LIST BELOW OR ATTACH YOUR OWN LIST.

NAME	STRENGTH	HOW OFTEN

DO YOU TAKE ANY BLOOD THINNING MEDICATION? E.g. rivaroxaban, aspirin, fish oil
If you have ceased this medication, when did you take your last dose?

DO YOU TAKE ANY WEIGHT LOSS MEDICATION? E.g. Ozempic, Wegovy, Saxenda, Mounjaro
If you have ceased this medication, when did you take your last dose?

DO YOU TAKE ANY OVER THE COUNTER MEDICATION (INCLUDING HERBS, SUPPLEMENTS)?

DO YOU HAVE ANY ALLERGIES?

PATIENT MEDICAL HISTORY 1

Patient's Name: _____ Date of Birth: ___/___/___

Prior to your surgery, it is extremely important that we are aware of some of your previous medical history. To help us gather this information, please answer the following questions.

NUMBER OF PREGNANCIES: ____ **NUMBER OF CHILDREN: ____**

Have you taken hormone replacement therapy for menopausal symptoms? Yes / No

CURRENT SYMPTOMS:
Please indicate whether you have any of the following symptoms currently.

Pain? Yes / No _____

Vaginal bleeding? Yes / No _____

Issues passing urine? Yes / No _____

Issues opening bowels? Yes / No _____

Other symptoms? _____

PREVIOUS SURGICAL PROCEDURES:
Please include all gynaecological and non-gynaecological surgical procedures.

SURGERY DATE	TYPE OF SURGICAL PROCEDURE

FAMILY CANCER HISTORY:
For aunts and grandparents, please include whether these were on mother's/father's side.

SOCIAL HISTORY:

Do you currently smoke? Yes / No Do you drink >2 drinks of alcohol per day? Yes / No

How far could you walk on flat ground? _____

Can you walk up a flight of stairs? Yes / No _____

If you have surgery, who would be able to support you when going home from hospital?

_____

PATIENT MEDICAL HISTORY 2

Patient's Name: _____ Date of Birth: ___/___/___

CURRENT MEDICAL CONDITIONS:
To make sure we don't miss any important medical conditions, please answer yes/no to a list of common medical conditions then provide further details beside or in the box below. If you have recently seen a specialist (e.g. cardiologist), please include their name.

Diabetes Mellitus: Type 1 / Type 2 _____

High blood pressure: Yes / No _____

Lung condition: Yes / No _____

Heart condition: Yes / No _____

Vascular / clots: Yes / No _____

Kidney / bladder: Yes / No _____

Brain / neurological: Yes / No _____

Gastrointestinal/liver: Yes / No _____

Muscular/Skeletal: Yes / No _____

Thyroid/endocrine: Yes /No _____

Please provide any further details of current medical conditions below.

EXAMINATION
BODY WEIGHT (kg): _____ HEIGHT (cm): _____

Professor Obermair generally performs an examination as part of his assessment. This may involve examining the abdomen, groins and vulva/vagina including a speculum exam. If indicated, he may perform digital rectal exam.

Do you consent to this examination? Yes / No
Would you like a chaperone to be present in the examination room? Yes / No

PLEASE BRING RELEVANT MEDICAL IMAGING REPORTS WITH YOU FOR YOUR CONSULTATION.