Patient ID label

the San DAY SURGERY HORNSBY

PATIENT HISTORY FORM

Surname .....

Given Names .....

D.O.B. .....

Admission Date	Admitting Doctor
2 0	

Please answer EVERY question (both sides of form)

PATIENT HISTORY (*please circle* the appropriate answer *or tick* the appropriate box)

	Planned procedure			Is this admission the result of a past injury? *Specify cause & place*	Y	N
Endo.	Diabetes Controlled by: ☐ diet ☐ tablet ☐ injection	Y	N	Thyroid problems	Y	N
Resp.	Bronchitis / asthma / emphysema etc *Specify* Do you use: ☐ nebulisers ☐ puffers ☐ home oxygen	Y	N	Recent cold	Y	N
				Other lung problems *Specify*	Y	N
Cardiovascular	High blood pressure	Y	N	Chest pain / angina	Y	N
	Previous deep vein thrombosis / pulmonary embolism / varicose veins *Specify*	Y	N	Palpitations / heart murmur / irregular heart beat / AF *Specify*	Y	N
	Artificial implants / devices / grafts: ☐ coronary artery bypass ☐ coronary/vascular stent ☐ artificial heart valve ☐ pacemaker	Y	N	*Specify*		
GIT	Gastric ulcer / reflux / hiatus hernia	Y	N	Hepatitis	Y	N
	Jaundice	Y	N	Stoma	Y	N
Musculo-skeletal	Arthritis	Y	N	Hip / knee replacements *Specify*	Y	N
	Back / neck injury or problems *Specify*	Y	N	Other implants / devices *Specify*	Y	N
Neurology	Fits / faints / funny turns / epilepsy	Y	N	Speech / swallowing problems	Y	N
	Stroke / mini stroke / TIA *If yes, any residual weakness, please specify*	Y	N	Limb paralysis ☐ right arm ☐ left arm ☐ right leg ☐ left leg	Y	N
	Previous falls / unsteady on feet	Y	N	Polio / meningitis *Specify*	Y	N
	Short term memory loss / dementia / developmental delay *Specify*	Y	N	***NB: you may be asked to provide a family member or carer to be in attendance during your stay***		
Renal	Kidney trouble / dialysis / renal impairment	Y	N	Bladder problems ☐ urinary incontinence ☐ frequency ☐ urgency ☐ pain	Y	N
	Stoma *Specify*	Y	N			
General Health	Have you ever smoked?	Y	N	*If yes*, daily amount ☐ Date ceased ☐		
	Do you presently smoke?	Y	N	*If yes,* ☐ per day		
	Do you drink alcohol?	Y	N	☐ standard drinks per day		
	Past history of drug dependency	Y	N	*Specify*		
	Disturbed sleep pattern / sleep apnoea	Y	N	☐ CPAP used		
	Could you be pregnant?	Y	N			
	Do you have chronic pain?	Y	N	*Specify*		
	Do you have a history of pressure areas?	Y	N	*Specify*		
	Do you have a current pressure area or any areas of broken skin?	Y	N	*Specify*		
	Do you have a history of a multi-resistant organism? eg. MRSA, VRE, other	Y	N			
Previous Surgery	eg. Coronary artery bypass, brain, liver or pancreatic surgery, hip replacements	Y	N	*Specify*		
	Problems with anaesthetic eg. nausea, vomiting, malignant hyperthermia	Y	N	If Yes, ☐ self ☐ family *Specify*		
	Cancer Date: / / Site:	Y	N	Treatment ☐ surgery ☐ chemotherapy ☐ radiotherapy		
	Transplants	Y	N	*Specify*		
Other	Do you have Creutzfeldt-Jakob Disease (CJD)?	Y	N	*Specify*		
	Have you had Human Pituitary Growth Hormone prior to 1985?	Y	N	*Specify*		
	Have you had neurosurgery prior to 1985?	Y	N	*Specify*		

PATIENT HISTORY FORM (SDSH)

MR 26AS

MR26ASP1

Patient ID label

Surname .....

Given Names .....

D.O.B. .....

PATIENT HISTORY FORM (continued)

Height & weight details	**Height** ____ cm		**Weight** ____ kg	
Dietary Requirements	Do you have a special diet? ☐ No ☐ Yes (specify)			
Prosthetics / Aids / Other				
Visual aids	Y	N	☐ Glasses ☐ Contact lenses ☐ Eye prosthesis	
Hearing aids	Y	N	☐ Left ☐ Right	
Walking aids	Y	N	*Specify*	

Allergies & Sensitivities

Please document any known allergies or sensitivities eg. medications, latex, plants, tape

Allergies	Sensitivities	Reaction

Food allergy

Your current Medications

Please include tablets, capsules, puffers, nebulisers, patches, insulin, eye drops. *Consult your GP or surgeon if you are unsure of any details about your medications or which medications should be ceased prior to your surgery.* ***Bring to the hospital all current medication you are taking, in their original individual packaging (ie. not in Webster or Doset packs)***

Prescription Medication	Strength	Dose & Frequency	Purpose
Geranin (example)	100mgs	one tablet twice a day	

If you are taking any non-prescription medication eg. Complementary therapies, natural therapies, herbal preparations or vitamins, please specify

NB: All complementary medicine should be ceased 10 days prior to admission (unless otherwise instructed by your doctor)

Non- Prescription Medication	Strength	Dose & Frequency	Purpose

Discharge Planning & community support

Do you live alone? ☐ Yes ☐ No If not, with whom?

Who is your main carer?

Do you receive community services? ☐ Yes ☐ No If Yes, ☐ Nurses ☐ Home Care ☐ Meals on Wheels

Going home

Who will be taking you home and be with you for 24 hours?

Name	Relationship
Best contact phone no	Or mobile no.

SIGNATURE PATIENT / CARER

I have carefully read all the above and I certify that the information I have given is correct and true to the best of my ability.

Signature .....

Date ...../...../20.....

Form completed by:

Patient ...../Sign.

Carer ...../Sign.

MR26ASP2