

PATIENT HISTORY FORM

Surname		MRN	ACN
Date of birth		Given Names	
Sydney contact phone no.		Phone No.	
Admission Date		Mobile No.	
		Admitting Doctor	

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



MRN

Surname

Given Names

DOB

PATIENT HISTORY FORM (continued)

Height & weight details		Height <input type="text"/> cm	Weight <input type="text"/> kg
Dietary Requirements		Do you have a special diet? <input type="checkbox"/> No <input type="checkbox"/> Yes (specify)	
Prosthetics / Aids / Other			
Visual aids	Y N	<input type="checkbox"/> Glasses <input type="checkbox"/> Contact lenses <input type="checkbox"/> Eye prosthesis	
Hearing aids	Y N	<input type="checkbox"/> Left <input type="checkbox"/> Right	
Walking aids	Y N	Specify	
Allergies & Sensitivities		<i>Please document any known allergies or sensitivities eg. medications, latex plants, tape</i>	
Allergies	Sensitivities	Reaction	
Food allergy			
Your current Medications		<i>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)</i>	
Prescription Medication	Strength	Dose & Frequency	Purpose
Geranin	100mgs	one tablet twice a day	
<i>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)</i>			
Non- Prescription Medication	Strength	Dose & Frequency	Purpose
Discharge Planning & community support		Do you live alone? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, with whom?	
		Who is your main carer?	
		Do you receive community services? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, <input type="checkbox"/> Nurses <input type="checkbox"/> Home Care <input type="checkbox"/> Meal 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		Form completed by:	
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.		Patient/Sign.	
Signature		Carer/Sign.	
Date/...../.....			