the San DAY SURGERY HORNSBY

PATIENT HISTORY FORM

- Have you had an admission to San Day Surgery within the past 6 months? ☐No ☐Yes If yes, please sign here if there have been no changes in your medical history in the last 6 months.

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

- If there have been changes within the last 6 months, or if you have not been here within the previous 6 months, please complete the patient history form.

Patient ID label

Family Name.....

Given Name(s) .....

D.O.B. .....

Admission Date	Admitting Doctor
2 0	

Please answer EVERY question (both sides of form)

Do you have or have you had:						
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	Y	N	☐ Palpitations ☐ Heart murmur ☐ Irregular heart beat ☐ AF	Y	N
	Artificial implants / devices / grafts: ☐ coronary artery bypass ☐ coronary/vascular stent ☐ artificial heart valve ☐ pacemaker				Y	N
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	Do you, or have you smoked in the past?	Y	N	*If yes*, daily amount ☐ Date ceased ☐		
	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		
	Depression / mental illness / anxiety	Y	N	*Specify*		
	Could you be pregnant?	Y	N			
	Do you have chronic pain?	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 / Lymphoma / Leukaemia Date: / / Site:	Y	N	Treatment ☐ surgery ☐ chemotherapy ☐ radiotherapy		
	Transplants	Y	N	*Specify*		
Other	Do you, or any relatives, have Creutzfeldt-Jakob Disease (CJD)?				☐ No	☐ Yes
	Do you have a 'medical in confidence' letter regarding CJD?				☐ No	☐ Yes
	Have you had Human Pituitary Growth Hormone prior to 1986, or neurosurgery/spinal surgery prior to 1990?				☐ No	☐ Yes
	Do you have an unexplained progressive neurological illness in the last 12 months?				☐ No	☐ Yes

PATIENT HISTORY FORM (SDSH)

MR 26AS

MR26ASP1

Patient ID label

Family Name .....

Given Name(s) .....

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*	
Dentures	Y N	☐ Upper ☐ Partial ☐ Full ☐ Lower ☐ Partial ☐ Full	

Allergies & Sensitivities

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

Allergies / Adverse Drug Reactions	Sensitivities	Reaction

Food allergy

Your current Medications

Please include tablets, capsules, puffers, nebulisers, patches, insulin, eye drops. *Consult your GP or specialist(s) 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

Does someone assist you to manage your medications at home? ☐ Yes (who.....) ☐ No

Discharge planning & social aspects

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