San Day Surgery Hornsby

PATIENT HISTORY FORM

Patient ID label

Family Name...

Given Name(s) ....

D.O.B. ....

- 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.

Admission Date	Admitting Doctor
20	

Please answer EVERY question on both sides of form if an eAdmission cannot be completed

Return to: San Day Surgery Hornsby 1a Northcote Rd Hornsby 2077 or email to sandaysurgeryhornsby@sah.org.au

Do you have or have you had:

Section	Question	Y/N	Question	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	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 / delirium / developmental delay, *please 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

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.