ST. KILDA DAY HOSPITAL

HEALTH INFORMATION

Patient Label

Please tick appropriate box

Height_____cm Weight _____kg

Heart Attack/ Heart Trouble/ Pacemaker	Yes ☐ No ☐	Epilepsy / Fits	Yes ☐ No ☐
Palpitations	Yes ☐ No ☐	Indigestion Pain/ Heartburn	Yes ☐ No ☐
Chest Pain	Yes ☐ No ☐	Liver Problems	Yes ☐ No ☐
Shortness of breath/ breathing problems	Yes ☐ No ☐	Hay fever	Yes ☐ No ☐
Chest trouble/lung disease	Yes ☐ No ☐	Persistent cough	Yes ☐ No ☐
Sleep Apnoea	Yes ☐ No ☐	Ladies, are you pregnant	Yes ☐ No ☐
High Blood Pressure	Yes ☐ No ☐	Asthma/bronchitis	Yes ☐ No ☐
Stroke	Yes ☐ No ☐	Bleeding/ Bruising Problems	Yes ☐ No ☐
Hepatitis A, B or C, HIV	Yes ☐ No ☐	Anaemia or Blood Problems	Yes ☐ No ☐
Dizziness/ Fainting	Yes ☐ No ☐	Advanced Care Plan	**Yes** ☐ No ☐
Cortisone (steroids) in the last 6 months	Yes ☐ No ☐	Update My Health Record	**Yes** ☐ No ☐
Do you have false teeth or caps	Yes ☐ No ☐		
Do you smoke or did you smoke	Yes ☐ No ☐	If yes, how may per day?	_____
Do you consume alcohol	Yes ☐ No ☐	If yes, amount per day?	_____
Do you take any recreational drugs	Yes ☐ No ☐		
Are you on any blood thinning medication	Yes ☐ No ☐	If yes, name of medication	_____
Are you on any diabetic medication for diabetes?	**Yes** ☐ No ☐	If yes, name of medication	_____
Have you been unwell in the last 2 weeks (eg cold/flu)	Yes ☐ No ☐		
Have you had an infectious disease in the last 6 months	Yes ☐ No ☐	If yes, please specify:	_____
Have you ever had MRSA or VRE	Yes ☐ No ☐		
Have you had an adverse drug reaction	**Yes** ☐ No ☐	If yes please specify:	_____
Did you have a blood transfusion between 1980-1985	Yes ☐ No ☐		
Have you had a dura mater graft (prior to 1989)	Yes ☐ No ☐		

Do you have a family history of two or more first-degree relatives with Creutzfeldt-Jakob disease or other unspecified progressive neurological disorder Yes ☐ No ☐

Have you been admitted to hospital in the last 28 days Yes ☐ No ☐

Have you received human pituitary hormones prior to 1986 Yes ☐ No ☐

Have you had a fall during the last 12 months **Yes** ☐ No ☐

Do you use any aids Eg walking stick, frame**:** **Yes** ☐ No ☐ Details: _____

Do you have areas of delicate skin, abrasions, wounds, sores, laceration **Yes** ☐ No ☐ Details: _____

Dementia/ Confusion **Yes** ☐ No ☐

Intellectual Disability **Yes** ☐ No ☐

Delirium/ Post Anaesthetic Confusion **Yes** ☐ No ☐

History or mental illness eg depression, psychosis, self harm **Yes** ☐ No ☐ Details: _____

Patient Label

Please List any Medications you are taking (including complimentary/vitamins) _____

_____

_____

Are you allergic to anything? (medications, tapes, food, latex) **Yes** ☐ No ☐ Details: _____

_____

Please list any Medical Conditions: _____

_____

Please list any Previous operations: _____

_____

Have you or a relative had any problems with anaesthetic in the past? Yes ☐ No ☐ Details: _____

Date Form Completed: _____

OFFICE USE ONLY

Exclusion Criteria: ASA 3 and above, Under 18, BMI over 38, Weight over 120 kgs

PRE-ADMISSION ASSESSMENT **Date:** _____ **Time:** _____

Procedure: _____ Surgeon _____ Within Scope of Practice? Yes ☐ No ☐

Weight: _____kg BMI _____

Diabetic / anti-coagulant medications? Yes ☐ No ☐ If yes, advice given? Yes ☐ No ☐ _____

Further consultation with Surgeon or Anaesthetist required? Yes ☐ No ☐

Pre-operative phone call by Anaesthetist received? Yes ☐ No ☐

Discharge responsible adult assigned? Yes ☐ No ☐

Pre-admission complete? Yes ☐ No ☐ Approved? Yes ☐ No ☐

Action: _____

_____

_____

_____

Name: _____ Signature: _____ Date: _____