SPRINGWOOD DAY SURGERY

HEALTH ASSESSMENT

Record No: .....

Surname: .....

Given Names: .....

DOB: ..... Sex: .....

AFFIX PATIENT IDENTIFICATION LABEL HERE

PLEASE COMPLETE FORM IN **BLOCK LETTERS.** PROVIDE AS MUCH DETAIL AS POSSIBLE TO ALLOW US TO ENSURE YOUR SAFE & OPTIMAL CARE

REASON FOR ADMISSION TO HOSPITAL:	ADMITTING DOCTOR:

HEALTH AND RISK ASSESSMENT - DO ANY OF THE OF THE FOLLOWING APPLY

ALLERGIES OR ADVERSE REACTIONS : ☐ YES: ☐ NO:

☐ LATEX: ☐ FOOD: ☐ SKIN PREP: ☐ MEDICATION: ☐ TAPES:

☐ OTHER: .....

IF YOU ANSWERED YES TO ANY OF THE QUESTIONS PLEASE PROVIDE DETAILS:

ASTHMA / BRONCHITIS	☐ YES:	☐ NO:
HAVE YOU EVER BEEN HOSPITALISED FOR ASTHMA / BRONCHITIS	☐ YES:	☐ NO:
SLEEP APNOEA / INVESTIGATIVE SLEEP STUDIES	☐ YES:	☐ NO:
CPAP MACHINE ADVISED	☐ YES:	☐ NO:
INFECTION WITH MULTI-RESISTANT ORGANISM (eg: golden staph)	☐ YES:	☐ NO:
DIABETES ☐ INSULIN ☐ TABLET ☐ DIET	☐ YES:	☐ NO:
PLEASE ENSURE YOU BRING YOUR MEDICATIONS TO HOSPITAL WITH YOU		
PREVIOUS BLOOD CLOTS	☐ YES:	☐ NO:
BLOOD THINNING MEDICATION (ie:Plavix, Cartia, Astrix)	☐ YES:	☐ NO:
PLEASE ENSURE YOU FOLLOW YOUR DOCTOR'S INSTRUCTIONS REGARDING THIS MEDICATION		
HEART ATTACK / ANGINA	☐ YES:	☐ NO:
ARTIFICIAL HEART VALVE / IMPLANT / DEFIBRILLATOR / PACEMAKER	☐ YES:	☐ NO:
EPILEPSY / FITS / SEIZURES	☐ YES:	☐ NO:
ANAESTHETICS DIFFICULTIES	☐ YES:	☐ NO:

HEIGHT WEIGHT

YOUR PHYSICAL HEALTH - DO ANY OF THE OF THE FOLLOWING APPLY

IF YOU ANSWERED YES TO ANY OF THE QUESTIONS PLEASE PROVIDE DETAILS:

HIGH BLOOD PRESSURE	☐ YES:	☐ NO:
BLOOD DISEASE / DISORDER	☐ YES:	☐ NO:
LIVER DISEASE / DISORDER	☐ YES:	☐ NO:
KIDNEY DISEASE / DISORDER	☐ YES:	☐ NO:
IRREGULAR HEARTBEAT OR MURMUR	☐ YES:	☐ NO:
STROKE CVA	☐ YES:	☐ NO:
GASTRIC REFLUX / HIATUS HERNIA	☐ YES:	☐ NO:
NEUROLOGICAL CONDITION	☐ YES:	☐ NO:
SIGNIFICANT BACK / NECK INJURY	☐ YES:	☐ NO:
ORGAN FAILURE / TRANSPLANT	☐ YES:	☐ NO:
ANY FORM OF CANCER	☐ YES:	☐ NO:
ANY OTHER ILLNESS / CONDITION	☐ YES:	☐ NO:

YOUR MOBILITY / DAILY ACTIVITIES - PLANNING FOR DISCHARGE

DO YOU HAVE DIFFICULTY WITH WALKING OR REQUIRE AIDES	☐ YES:	☐ NO:	ARE YOU MANAGING AT HOME	☐ YES	☐ NO:
HAVE YOU HAD ANY RECENT FALLS	☐ YES:	☐ NO:	ARE YOU A PRIMARY CARER FOR SOMEONE ELSE	☐ YES	☐ NO:
DO YOU LIVE ALONE	☐ YES:	☐ NO:	DO YOU NEED ACCOMMODATION ASSISTANCE	☐ YES	☐ NO:
DO YOU HAVE DIFFICULTY SHOWERING OR DRESSING	☐ YES:	☐ NO:	DO YOU USE COMMUNITY SUPPORT SERVICES	☐ YES	☐ NO:

REFERRAL FAXED: ☐ YES: DATE: ACTIONED BY DISCHARGE NURSE: ☐ YES: DATE:

SPRINGWOOD DAY SURGERY

HEALTH ASSESSMENT

Record No: .....

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SPECIAL PROCEDURES AND DISEASES - DO ANY OF THE OF THE FOLLOWING APPLY

YOU RECEIVED A DURA MATER GRAFT BETWEEN 1972 AND 1989	☐ YES:	☐ NO:
YOU RECEIVED HUMAN PITUITARY HORMONE (GROWTH, GONADOTROPHIN) PRIOR TO 1985	☐ YES:	☐ NO:
YOU, OR TWO OR MORE FIRST-DEGREE FAMILY MEMBERS, HAVE A HISTORY OF CREUTSFELDT-JACOB DISEASE (CJD) OR RELATED DISEASE	☐ YES:	☐ NO:

SPECIFIC PROCEDURES AND SURGERY - DO ANY OF THE OF THE FOLLOWING APPLY

PAST BLOOD TRANSFUSION	☐ YES:	☐ NO:
ANGIOGRAM	☐ YES:	☐ NO:
CHEMOTHERAPY / RADIATION THERAPY	☐ YES:	☐ NO:
SURGERY (PLEASE LIST)	☐ YES:	☐ NO:

IF YOU ANSWERED YES TO ANY OF THE QUESTIONS PLEASE PROVIDE DETAILS:

YOUR PERSONAL AND EMOTIONAL HEALTH - DO ANY OF THE OF THE FOLLOWING APPLY

CURRENTLY OR POSSIBLY PREGNANT?	☐ YES:	☐ NO:	
PROBLEMS WITH YOUR BLADDER?	☐ YES:	☐ NO:	
UNEXPLAINED WEIGHT LOSS / GAIN?	☐ YES:	☐ NO:	
DID YOU OR DO YOU SMOKE?	☐ YES:	☐ NO:	
HOW MANY PER DAY? IF STOPPED, WHEN?			
DO YOU DRINK ALCOHOL?	☐ YES:	☐ NO:	
HOW MANY? HOW OFTEN?			
ANY HEARING DIFFICULTY?	☐ YES:	☐ NO:	
☐ LEFT EAR ☐ RIGHT EAR ☐ HEARING AID ☐ LIP READING			
ANY VISION DIFFICULTY?	☐ YES:	☐ NO:	
☐ LEFT EYE ☐ RIGHT EYE ☐ GLASSES ☐ CONTACT LENS			
PROBLEMS WITH YOUR BOWELS?	☐ YES:	☐ NO:	
EATING / SWALLOWING DIFFICULTIES?	☐ YES:	☐ NO:	
ANY RASHES / BRUISING / CUTS / ULCERS?	☐ YES:	☐ NO:	
ANXIETY OR DEPRESSION?	☐ YES:	☐ NO:	
ANY DEMENTIA OR MEMORY LOSS?	☐ YES:	☐ NO:	
ANY RECENT SIGNIFICANT EVENTS IN YOUR LIFE?	☐ YES:	☐ NO:	
ANY PAIN MANAGEMENT PROBLEMS?	☐ YES:	☐ NO:	
ANY PSYCHOLOGICAL DISORDERS?	☐ YES:	☐ NO:	
ANY SLEEPING DIFFICULTY?	☐ YES:	☐ NO:	
ANY DENTAL ISSUES?	☐ YES:	☐ NO:	
☐ UPPER: ☐ LOOSE TEETH: ☐ BRACES: ☐ BRIDGES: ☐ LOWER ☐ CAPS/CROWNS: ☐ DENTURES: ☐ BROKEN TEETH:			

DETAILS / COMMENTS:

PLEASE TELL US IF YOU HAVE ANY DIETARY RESTRICTIONS (EG: DIABETIC, GLUTEN FREE ETC):

IF YOU ARE HAVING A DAY PROCEDURE, WOULD YOU LIKE US TO TELEPHONE YOU ON THE FOLLOWING BUSINESS DAY TO ENSURE YOU ARE RECOVERING WELL? IF YES, NOMINATE BEST TELEPHONE NUMBER TO CONTACT YOU ON. ..... ☐ YES: ☐ NO:

AS PER ANZCA GUIDELINES, AFTER A DAY PROCEDURE YOU ARE REQUIRED TO HAVE A CARER COLLECT YOU AND LOOK AFTER YOU FOR 24 HOURS.

FOR YOUR SAFETY, PUBLIC TRANSPORT IS NOT SUITABLE FOR TRANSPORT AFTER SEDATION OR GENERAL ANAESTHESIA. PLEASE NOMINATE A CARER AND TRANSPORT ARRANGEMENT FOR GOING HOME

NAME: TELEPHONE: TRANSPORT:

THE INFORMATION I HAVE PROVIDED HERE IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE

PATIENT SIGNATURE:		DATE:
NURSE SIGNATURE:	NAME:	DATE:

SPRINGWOOD DAY SURGERY 52 CINDERELLA DRIVE SPRINGWOOD QUEENSLAND 4127 P: 07 2802 4499 F: 2802 4477 E: INFO@SPRINGWOODDAYSURGERY.COM.AU