Bundaberg Private Day Hospital	**MR1.2 Health Assessment**	

Surgery Booking (to be completed by Surgeon's Rooms):

Date of admission:	Surgeon:
Procedure:	

Patient details:

Title:	Surname:	Given Names:

Do you consent to the hospital communicating with your General Practitioner if required? ☐ **yes** ☐ **no**

Doctor's Name:	Practice Name:
Address:	Telephone:

Patient Medical History (to be completed by patient or GP):

Physical	Height cm		Weight kg	
Previous Surgery	List details of previous surgery and dates:			
Cardiac	Hypertension/high blood pressure	☐ yes ☐ no	Rheumatic fever	☐ yes ☐ no
	High Cholesterol	☐ yes ☐ no	Blood clot on lungs/legs (DVT)	☐ yes ☐ no
	Do you smoke? Number of cigarettes per day:	☐ yes ☐ no	Anemia	☐ yes ☐ no
	Heart attack / AMI Date	☐ yes ☐ no	Chest pain / Angina	☐ yes ☐ no
	Diabetes ☐ Type 1 ☐ Type 2 ☐ IDDM Insulin Dependent ☐ NIDDM Diet controlled, insulin, tablet	☐ yes ☐ no	Do you have a joint or heart valve replacement, angioplasty / stent, pacemaker/defibrillator or eye implant	☐ yes ☐ no
Respiratory	Chronic obstructive airway disease	☐ yes ☐ no	Shortness of breath	☐ yes ☐ no
	Asthma/Bronchitis	☐ yes ☐ no	Tuberculosis	☐ yes ☐ no
	Pneumonia	☐ yes ☐ no	Have you recently had a cough, cold or sore throat?	☐ yes ☐ no
Vascular	Peripheral Vascular Disease	☐ yes ☐ no	Pressure Ulcer Where:	☐ yes ☐ no
GIT/GUT	Indigestion or reflux	☐ yes ☐ no	Hepatitis or jaundice	☐ yes ☐ no
	Kidney disease	☐ yes ☐ no	Liver disease	☐ yes ☐ no
Neuro	Stroke	☐ yes ☐ no	Back or neck problems	☐ yes ☐ no
	Epilepsy or other fits	☐ yes ☐ no	Stress related conditions	☐ yes ☐ no
	Fainting/Dizziness	☐ yes ☐ no	Sleep disorders	☐ yes ☐ no
Other	Cancer Type: Site/s:	☐ yes ☐ no	Have you had any reason to believe that you are in a high risk group for hepatitis or HIV (AIDS virus)?	☐ yes ☐ no
	Arthritis	☐ yes ☐ no		☐ yes ☐ no

	Eczema/Dermatitis	☐ yes ☐ no	Any other medical disease or illness	

Other	Have you or a member of your family ever had any problems with either local or general anaesthetics? Details:	☐ yes ☐ no	Do you tend to bleed or bruise easily? Details:	☐ yes ☐ no
	Hay fever	☐ yes ☐ no	Females: are you pregnant?	☐ yes ☐ no
	Have you ever had a blood transfusion? If yes, have you ever had a reaction?	☐ yes ☐ no ☐ yes ☐ no	Do you wear a dental appliance, cap, plate, crown or bridge?	☐ yes ☐ no
Lifestyle	Do you drink alcohol? Daily intake:	☐ yes ☐ no	Do you use or have used in the past year any recreational drugs? Details:	☐ yes ☐ no
Medication	Have you had any aspirin in the last week? How many and when:	☐ yes ☐ no	Do you take any unprescribed drugs or other substances? Details: In particular: fish oil, garlic capsules	☐ yes ☐ no
	Are you currently on Warfarin or anti-platelet drugs?	☐ yes ☐ no	Have you had any cortisone / steroids in the past 3 months If yes, state whether tablets, injection or cream:	☐ yes ☐ no
Current Medication	Drug		Dose	Frequency
Allergies	Do you have any allergies to tapes, lotions, food (e.g. Kiwi Fruit, banana), Latex or Rubber?	☐ yes ☐ no	Details:	
	Do you have any allergies to drugs?	☐ yes ☐ no	Details:	
	Do you have any other allergies?	☐ yes ☐ no	Details:	
CJD Risk Screening	Do you have a family history of 2 or more first degree relatives with Creutzfeldt-Jakob Disease or other undiagnosed neurological illness?	☐ yes ☐ no	Did you undergo surgery on the brain (neurosurgery) before 1990? What type of operation was performed and who was the surgeon/hospital?	☐ yes ☐ no
	To your knowledge did you receive pituitary hormone injections before 1986?	☐ yes ☐ no		
SARS	Have you been in contact with a person known to have SARS in the last 10 days?	☐ yes ☐ no	Have you travelled from overseas in the last 10 days?	☐ yes ☐ no

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: Print name: Date: