SOUTH BANK DAY HOSPITAL

Case No:

Pre-Admission Health Questionnaire

Name:_____
Date of Birth:_____
Best Contact Number:_____
Alternate Contact Number:_____

Please return completed form to: reception@sbdh.com.au

A PRE-ADMISSION NURSE WILL CONTACT YOU 2-5 DAYS PRIOR TO SURGERY

Admission Date:	____/____/____	**Surgeon:**	
Name of Operation:	Left ☐ Right ☐ Bilateral ☐ _____ _____		
Height: CM	**Weight:** KG	**Have you had a previous admission to South Bank Day Hospital?** Yes ☐ No ☐ Date:	
General Practitioner:	**Name:**_____ **Phone:**_____		

Religious or Cultural Requirements? Please advise

Interpreter Required? Yes ☐ No ☐ Details

ALLERGIES AND SENSITIVITIES

Have you ever had an ALLERGIC or ADVERSE reaction to:

Attach ADR Label

	YES	NO	PRODUCT NAME	TYPE OF REACTION
DRUG				
LATEX				
FOOD/OTHER				

Do you have any special dietary requirements	YES ☐ NO ☐	If yes, please give details?

ANAESTHETHIA AND OPERATION

Have you or any blood relative had any problems with an anaesthetic? YES ☐ NO ☐
If yes, please give details:

Previous operations

Please list previous operations, including site and date:
(*example: Left total hip replacement 2016*)

OPHTHALMIC HISTORY

Have you been diagnosed with an eye condition? (e.g. Glaucoma)

Please list any previous eye surgery, including which eye and date:

□Barcode□1

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AFFIX PATIENT LABEL

Cardiac	Yes	No	HOSPITAL USE ONLY
Have you ever had a heart attack? Which year?			
Have you ever had heart surgery? What type of surgery and which year? _____			
Do you have a pacemaker/internal defibrillator?			
Do you have cardiac stents or a prosthetic heart valve?			
Do you have angina or experience chest pain?			
Do you have an irregular heartbeat or palpitations?			
Do you have high blood pressure?			
Do you have any other heart problems? (e.g. heart failure)			
Do you see a cardiologist? If yes, please list their name and contact details._____			
Have you ever had a stroke?			
Have you ever had a blood clot/DVT/ Pulmonary Embolism? If yes, please give details:_____			
Do you have any other blood disorders?_____			
Diabetes			
Do you have diabetes? Type: Type 1 ☐ Type 2 ☐ Unsure ☐ Controlled by: Diet ☐ Tablet ☐ Insulin ☐			
Gastrointestinal			
Do you experience reflux or heartburn?			
Have you a hiatus hernia or gastro-intestinal ulcers?			
Skeletal / mobility			
Do you have a back/neck/jaw problem that restricts or limits your range of movement?			
Have you fainted or fallen in the last 3 months?			**Complete falls risk tool Score:** ☐
Do you use a walking stick, crutches, walking frame?			
Do you use a wheelchair? If yes, Can you stand to transfer independently?			
Are you able to lie flat for your procedure?			
Respiratory			
Do you smoke? Amount per day?			
Do you have asthma/bronchitis/emphysema/COPD?			
Have you been diagnosed with any sleeping disorders?			
At home, do you use CPAP ☐ EPEP ☐ Oxygen ☐			

AFFIX PATIENT LABEL

Infection Control	Yes	No	HOSPITAL USE ONLY
Do you have a family history of two or more first degree or second degree relatives with Creutzfeldt-Jakob (Mad Cow) disease or other unspecified neurological disorder?			
Have you previously had surgery on the brain or spinal cord that included a dura mater graft (prior to 1990)?			
Have you received human pituitary hormone for infertility or human growth hormone for short stature (prior to 1986)?			
Have you had an unexplained progressive neurological illness in the last 12 months?			
Have you been involved in a 'look back' for cCJD or been given a 'medical in confidence letter' regarding your risk for cCJD?			
Have you ever tested positive for Hepatitis A or B or C, HIV, TB?			
Have you ever had a hospital acquired infection (e.g. MRSA, VRE, CRE, Clostridium difficile)? If yes, when?			
Have you had an overnight stay in an overseas hospital within the last 12 months?			
Have you recently returned from overseas within the last 4 – 6 weeks?			
Have you been exposed to an infectious disease (e.g. chicken pox or measles) in the last 14 days?			
Have you had a cold, flu, fever or cold sore in the last 7 days?			
Are you currently taking antibiotics for any type of infection? If yes, please give details:_____			
Do you have any broken skin areas? Wounds/ Cuts/ Ulcers/ Pressure Sores.			**Complete Norton Scale Risk Assessment Tool Score:**
Prostheses/Aids			
Do you wear glasses or contact lenses?			
Do you use a hearing aid/other hearing appliance?			**Please wear your hearing aids into the hospital.**
Do you have dentures/caps/crowns/loose teeth?			
Do you have an artificial joint / limb/ pins/ plates? Where?			
Do you have any artificial implanted devices or body implants? (CVAD, fistula, breast implants, gastric band, etc.)			
General Health and Wellbeing			
Have you been diagnosed with cancer? If yes, please give details:_____			
Do have depression, anxiety or any other mental health diagnosis?			
Do you have any disabilities? If yes, please give details_____			
Do you have any memory impairment?			
Do you have any significant medical conditions? Epilepsy/ Thyroid Disease/ Liver Disease/ Parkinson's Disease/ Kidney Disease, etc.?			
Do you drink alcohol? How many per day?			
Do you take illicit drugs?			
If female and of child bearing age, are you pregnant?			

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AFFIX PATIENT LABEL

Medications			HOSPITAL USE ONLY
PLEASE LIST ALL OF YOUR CURRENT MEDICATIONS: Include all prescription, non-prescription, vitamins, herbal tablets or remedies.			
Drug Name	**Dose**	**Frequency**	
Do you take blood thinning medication? Yes ☐ No ☐ e.g. Warfarin, Plavix, Aspirin, Fish Oil, Garlic Tablets, Anti-Inflammatory Medications, etc **Ask your Surgeon for advice about stopping or continuing these medications** Have you ever taken **FLOMAXTRA?** (or any Alpha1 Blocking Antagonist Medications) Yes ☐ No ☐			INR result: Date last taken: / /

Patients receiving General Anaesthesia or IV Sedation

Following surgery, I will have a responsible adult drive me/accompany me home and stay with me for the 24 hours following discharge. I realise mental impairment may persist for several hours following the administration of anaesthesia.

The answers I have given are true to the best of my knowledge and no information has been withheld.

Patient Signed:		**Date:**	

Nurse to initial when patient is advised of the following admission details:

Admission Time:		**Remove Jewellery/ Piercings/Watches**	
Fasting Time – Food:		**Expected Length of Stay**	
Fasting Time – Water:		**DVA Transport Required?** Yes ☐ No ☐	
Admission Floor Location – Level One		**DVA Transport organised by:**	
Parking Facilities		**DVA Booking Ref:**	
Pre-Operative Shower/Hair Wash		**Carer Confirmed**	
No Make-up/Perfume/Nail Polish		**Name of Carer:**	

Comments:

Call Attempts: 1._____ 2. _____ 3. _____

By signing this document, the pre-admission clinic nurse confirms that all questions contained within have been asked of the patient and details provided where required.

Nurse Signature:_____ **Date:**_____/_____/_____