Darwin Day Surgery

Short Stay Pre-Admission Health Assessment Form

Affix Patient Label Sticker Here

Name: _____ **Date of Birth**: ___ / ___ / ___ **Primary Phone No**: _____

Planned Procedure: _____ **Admission Date:** _____

***Nurse Use Only*:** patient I.D., procedure, and date checked and correct: **YES** ☐ **NO** ☐

Please complete the following health questionnaire *(please circle the appropriate answer, tick where appropriate, and provide further information where indicated)*

Height & Weight Details	Height (cm): Weight (kg): BMI: (kg/m^2)
Visual aids	**Y N** ☐ Glasses ☐ Contact Lenses ☐ Eye prosthesis
Hearing aids	**Y N** ☐ Left ☐ Right
Walking aids	**Y N** Specify:

Affix Medical Alert Sticker Here

Do you have, or have you ever had:	**Yes No**	**Details**
Do you have any **ALLERGIES**? *Including **medications**, **latex**, **food** etc.* What are they and what kind of reaction do you have? Please list in next column --------→	**Y N**	
Heart trouble, palpitations, heart disease, heart attack, chest pain or pain on exertion (angina)	**Y N**	Specify: When:
Artificial heart valves, pacemakers, defibrillators	**Y N**	Specify:
Rheumatic fever	**Y N**	
High blood pressure	**Y N**	For how long?
Diabetes ☐ Type1 ☐ Type2	**Y N**	Controlled by: ☐ Diet ☐ Tablet ☐ Injection What are your usual blood sugars?
Blood clots (vein thrombosis, pulmonary embolus)	**Y N**	
Bleeding disorder / anaemia	**Y N**	
Have you ever had a blood transfusion?	**Y N**	Where and when:
Stroke / mini stroke / TIA / any residual weakness?	**Y N**	When:
Epilepsy / Seizures / Dizziness / Fainting (fear of needles?)	**Y N**	Specify: When:
Previous Falls or Unsteady on your feet	**Y N**	
Rheumatoid arthritis	**Y N**	Where:
Artificial joints / limbs or other body implants	**Y N**	Specify:
Back / neck injury or problems	**Y N**	Specify:
Do you have chronic pain?	**Y N**	Specify:
History of skin ulcers OR skin pressure injury	**Y N**	Specify:
Kidney problems / dialysis / kidney impairment	**Y N**	
Stomach ulcers or Heartburn or Reflux	**Y N**	Specify:
Jaundice or other liver condition **/ HIV or Hepatitis B or C**	**Y N**	Specify:
Tuberculosis now or in the past?	**Y N**	When:
Do you have **MRSA** Methicillin-resistant Staphylococcus aureus *or* **VRE** Vancomycin-resistant enterococci?	**Y N**	
Do you have **Creutzfeldt-Jakob Disease** (CJD)? *a rare brain disorder thought to be caused by an abnormal form of a protein called a 'prion'	**Y N**	Specify:
Have you had Human Pituitary Growth Hormone prior to 1985?	**Y N**	
Have you had neurosurgery (brain/spinal cord) prior to 1985?	**Y N**	

Reviewed: 16/09/2016 Review due: 16/09/2018

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Do you have, or have you ever had:	**Yes No**	**Details**
Have you been admitted overnight to any oversesas hospital or resided in an overseas residential aged care facility within the past 12 months?	**Y N**	If ***YES*** have you been tested for **CRE**? **YES NO** ***carbapenem-resistant enterobacteriaceae**
Sleep apnoea	**Y N**	What do you do about it?
Breathlessness on mild exertion or exercise	**Y N**	
Asthma or wheeziness; Hayfever or sinus problems	**Y N**	Specify:
Emphysema or bronchitis or frequent coughing	**Y N**	
Are you (could you be) pregnant?	**Y N**	If so, how many weeks?
Do you drink alcohol? **Y N** How many per week:		Do you smoke? **Y N** How many per day:
Have you taken any steroids (prednisolone or cortisone) in the last six months?	**Y N**	Specify:
Have you ever had an anaesthetic in the past?	**Y N**	Circle which: ***General Sedation Local***

Please list the procedures and year you have had aneasthetic in the boxes below: ***eg: Appendix 2010 or Caesarian 2013***

Have you (self or family) ever had any problems with anaesthetics? Eg: Malignant hyperthermia	**Y N**	Specify:

Any other medical conditions or history not mentioned in this form, please specify:

Please list **ALL REGULAR OR OCCASIONAL MEDICATIONS & VITAMINS & RECREATIONAL DRUGS you currently take in the table below**

Including: blood thinning medications, aspirin, warfarin, puffers/inhalers, patches, natural therapies or vitamins, oral contraceptive pill or implants, *AND* recreational drugs

Name of Medication	How much (dose)	How often (eg: daily)	**Name of Medication**	How much (dose)	How often (eg: daily)

****Who will be taking you home and be with you OVERNIGHT following your surgery?****
GENERAL ANAESTHETIC & SEDATION SURGERY ONLY

Name:	Relationship:	Phone No:

Who is your emergency / Next of Kin contact?

Name:	Relationship:	Phone 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 Patient / Carer: _____ **Date:** _____

Pre-admission Nurse Use Only: Patient Meets Darwin Day Surgery Criteria: **YES / NO**

Action taken: .....

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Nurse: ..... Signature: ..... Designation: ..... Date: .....