# PRE-ADMISSION ASSESSMENT

Unit Record Number: [ ][ ][ ][ ][ ][ ][ ][ ][ ]

Surname: ______________________________

Given Names: ______________________________

Date of Birth: [ ][ ] / [ ][ ] / [ ][ ][ ][ ]

Age: [ ][ ] Sex: [ ]

Medical Officer: ______________________________

*Affix Patients Identification Label*

**PATIENT HEALTH HISTORY** (Please complete all sections of this form and tick the appropriate answer in the appropriate box)

Admitting Surgeon: ______________________ Admission Date: _____ /_____ /______ Time: __________AM / PM

Procedure / Reason for Admission: ______________________________

What is your weight: ______________kg Height: ______________cm **BMI: > 35** [ ]

**HAVE YOU NOW, OR EVER BEFORE HAD** (Please ✔ tick your answer)

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Diabetes (Type 1) | [ ] | [ ] | Do you take Warfarin | [ ] | [ ] | Are you pregnant | [ ] | [ ] |
| Diabetes (Type 2) | [ ] | [ ] | Anaemia | [ ] | [ ] | Mental Illness | [ ] | [ ] |
| Thyroid Problems | [ ] | [ ] | Heart Surgery | [ ] | [ ] | Dementia | [ ] | [ ] |
| Asthma (Please Bring Puffer) | [ ] | [ ] | Rheumatic Fever | [ ] | [ ] | Do you suffer from Epilepsy, Seizures, Blackouts | [ ] | [ ] |
| Emphysema/COPD | [ ] | [ ] | Reflux | [ ] | [ ] | | | |
| Sleep Apnoea | [ ] | [ ] | Kidney Disease | [ ] | [ ] | Do you currently have any Skin Wounds, Pressure Sores or Skin Ulcers | [ ] | [ ] |
| High Blood Pressure | [ ] | [ ] | Arthritis | [ ] | [ ] | | | |
| Heart Attack | [ ] | [ ] | Back / Neck Problems | [ ] | [ ] | Head cold or flu in the last 2 weeks | [ ] | [ ] |
| Angina | [ ] | [ ] | Liver Disease / Hepatitis | [ ] | [ ] | | | |
| Chest Pain | [ ] | [ ] | Joint Replacement | [ ] | [ ] | Have you or your family ever had a reaction to an Anaesthetic | [ ] | [ ] |
| Atrial Fibrillation | [ ] | [ ] | ______________________ | | | Date: ____ / ____ /_____ | | |
| Pacemaker | [ ] | [ ] | ______________________ | | | Have you ever had a Blood Transfusion | [ ] | [ ] |
| Heart Valve Replaced | [ ] | [ ] | ______________________ | | | | | |
| Blood Clot (Leg / Lungs) | [ ] | [ ] | Steroids / Cortisone | [ ] | [ ] | Date: ____ / ____ /_____ | | |

**DO YOU HAVE ANY ALLERGIES** [ ] **YES** [ ] **NO** (If yes. please give details below)

[ ] Drugs [ ] Tapes [ ] Latex [ ] Rubber [ ] Food

______________________________________________

**LIST OF MEDICATIONS INCLUDING PRESCRIBED & UNPRESCRIBED, HERBAL & RECREATIONAL DRUGS**

| Name of Medicine | How Much (dose) | How often (day) | Name of Medicine | How Much (dose) | How often (day) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**LIST DETAILS OF ANY PREVIOUS OPERATIONS**

Year:____________ Details: ______________________________

Year:____________ Details: ______________________________

Year:____________ Details: ______________________________

Year:____________ Details: ______________________________



**SEE REVERSE** ☞

**PRE - ADMISSION Assessment FORM**

**MR001**

## OTHER IMPORTANT INFORMATION

Do you have any special needs ☐ YES ☐ NO ______________________________

Do you smoke ☐ YES ☐ NO Amount: ______________ Date Ceased: _____ / ____ /______

Do you drink alcohol ☐ YES ☐ NO Amount: ______________

Do you have any special dietary needs ☐ YES ☐ NO Details: ______________________________

Have you ever had a test to show that you had Hepatitis B, Hepatitis C, HIV, MRSA, VRE or CRE ☐ YES ☐ NO

Details: ______________________________________________

Do you or your family have Creutzfeldt Jakob Disease (CJD) **Classical** ☐ YES ☐ NO **Variant** ☐ YES ☐ NO

Have you been admitted to an overseas hospital in the past 12 months ? ☐ YES ☐ NO Country: ______________

Have you been identified as a CRE contact ? ☐ YES ☐ NO

## ADMISSION FOR TREATMENT OF INJURY

Are you having treatment for an injury?" ☐ **YES** ☐ **NO**

If **"YES"**, Date of the Injury _____ / ____ /______

Please Describe:

How ? (eg. cut with a knife). ______________________________________________

Where ? (eg. kitchen, factory). ______________________________________________

Activity ? (eg. cooking, building). ______________________________________________

## DISCHARGE

If you are having a general anaesthetic or sedation **you will need to be escorted home** by a family member or friend.

Who will drive you home on day of surgery ? ______________________ Contact Phone No: ______________

Who will be staying with you on the night of surgery ? ______________________________

## SIGNATURE
### PATIENT / CARER

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: ______________________________ Date: _____ / _____ / _____

Form completed by: ______________________________

Patient Signature: ______________________ Carer: ______________________

## DATE REVIEWED BY REGISTERED NURSE

Further review required ☐ **YES** ☐ **NO**

By whom ? ☐ Anaesthetist ☐ Surgeon ☐ Nurse

Outcome: ______________________________________________

______________________________________________

______________________________________________

Name: ______________________ Signature: ______________________

Date: _____ / _____ / _____