Email phox.theatre.reception@ozcare.org.au
Phone 07 3180 0015 Fax 07 3028 9660

CANOSSA
PRIVATE HOSPITAL

Health Assessment

HOSPITAL ADMINISTRATION SECTION ONLY		
Family name:	First names:	
UR:	Date of birth:	Gender:
Affix patient label here:		

Patient Medical & Surgical History

SURGEON: DATE:

PROCEDURE:

Physical	DOB: ____ /____ /____	Age:	
	Height: (cm)	Weight: (kg)	
Cardiac	High blood pressure	☐ No ☐ Yes	
	High cholesterol	☐ No ☐ Yes	
	Anaemia	☐ No ☐ Yes	
	Chest pain / Angina	☐ No ☐ Yes	
	Heart attack / AMI	☐ No ☐ Yes	Date:
	Blood clot - lungs (PE) / legs (DVT)	☐ No ☐ Yes	
	Rheumatic fever	☐ No ☐ Yes	
	Smoking	☐ No ☐ Yes	Amount Daily:
Endocrine	Diabetes:	☐ No ☐ Yes If yes: ☐ Type 1 ☐ Type 2 ☐ IDDM Insulin Dependent ☐ NIDDM Diet / Insulin / Tablet	

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Respiratory	Chronic Obstructive Pulmonary Disease	☐ No	☐ Yes	
	Asthma	☐ No	☐ Yes	
	Bronchitis	☐ No	☐ Yes	
	Hay fever	☐ No	☐ Yes	
	Pneumonia	☐ No	☐ Yes	Date:
	Shortness of breath	☐ No	☐ Yes	Details:
	Recent infection (within 2 months)	☐ No	☐ Yes	Details:
Vascular	Peripheral Vascular Disease	☐ No	☐ Yes	
	Varicose veins	☐ No	☐ Yes	
	Poor circulation – hands / feet	☐ No	☐ Yes	
	Pressure Ulcer	☐ No	☐ Yes	Location:
	Venous Ulcer	☐ No	☐ Yes	Location:
GI	Indigestion / reflux	☐ No	☐ Yes	
	Bowel disease	☐ No	☐ Yes	
	Incontinence issues	☐ No	☐ Yes	☐ Bowel ☐ Bladder
	Kidney disease	☐ No	☐ Yes	
	Liver disease	☐ No	☐ Yes	
Neurological	Cognitive impairment	☐ No	☐ Yes	
	Dementia	☐ No	☐ Yes	
	Down Syndrome	☐ No	☐ Yes	
	Cerebral Palsy	☐ No	☐ Yes	
	Stroke	☐ No	☐ Yes	
	TIA – Transient Ischaemic Attack	☐ No	☐ Yes	
	Epilepsy / seizure	☐ No	☐ Yes	
	Sleep disorders	☐ No	☐ Yes	

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Neurological Continued	Fainting / dizziness (Within the last 12 months)	☐ No	☐ Yes	Details:
	Fall history (Within the last 12 months)	☐ No	☐ Yes	Details:
	Neck or spine issue	☐ No	☐ Yes	Details:
Mental	Do you have a diagnosed mental health condition?	☐ No	☐ Yes	Details:
	Have you had thoughts of self-harm or suicide? (Within the last 12 months)	☐ No	☐ Yes	Details:
	Do you have a history of aggression? (Within the last 12 months)	☐ No	☐ Yes	Details:
	Are you under the care of a doctor?	☐ No	☐ Yes	Details:
	Do you require additional support during your admission?	☐ No	☐ Yes	Details:
Dietary Needs	Specific nutritional requirements: (Including texture modified diets & fluids)	☐ No	☐ Yes	Details:
	Enteral feeding	☐ No	☐ Yes	
	Coeliac / gluten intolerant	☐ No	☐ Yes	
	Lactose intolerant	☐ No	☐ Yes	
	Vegetarian	☐ No	☐ Yes	
	Vegan	☐ No	☐ Yes	
	Halal	☐ No	☐ Yes	
	Kosher	☐ No	☐ Yes	
	Other	☐ No	☐ Yes	Details:

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Surgical History	Previous surgery	☐ No	☐ Yes	Details (List all surgeries):
	Anaesthetic issues – include family history	☐ No	☐ Yes	Details:
	History of Malignant Hyperthermia – self or direct family member?	☐ No	☐ Yes	Details:
	History of known difficult airway or intubation?	☐ No	☐ Yes	Details:
Allergies	Drug allergies	☐ No	☐ Yes	Details:
	Food allergies	☐ No	☐ Yes	Details:
	Previous anaphylaxis	☐ No	☐ Yes	Details:
	Other	☐ No	☐ Yes	Details:
Additional History	Pregnant ☐ N/A	☐ No	☐ Yes	
	Eczema / dermatitis	☐ No	☐ Yes	
	Arthritis	☐ No	☐ Yes	Details:
	Mobility aids	☐ No	☐ Yes	Details:
	Vision impaired / glasses	☐ No	☐ Yes	Details:
	Hearing impaired / aids	☐ No	☐ Yes	Details:
	Caps / crowns / dentures	☐ No	☐ Yes	Details:
	Fragile skin	☐ No	☐ Yes	Details:
	Bleed / bruise easily	☐ No	☐ Yes	Details:
	Blood transfusions	☐ No	☐ Yes	Details:
	Transfusion reactions	☐ No	☐ Yes	Details:
	Alcohol intake	☐ No	☐ Yes	Amount & Frequency:
	Recreational drugs	☐ No	☐ Yes	Type & Last Dose:

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Current Medication	Blood thinners	☐ No	☐ Yes	Details:
	Blood thinners ceased ☐ N/A	☐ No	☐ Yes	Date:
	Steroids / cortisone	☐ No	☐ Yes	Details:
	Steroids / cortisone ceased / last dose	☐ No	☐ Yes	Date:
	Cytotoxic medication	☐ No	☐ Yes	Details:
	Cytotoxic medication ceased / Last dose	☐ No	☐ Yes	Date:
	Prescribed medication list:			
	Non-prescribed medication list:			
Infectious Diseases	Overseas travel – previous 10 days	☐ No	☐ Yes	Details:
	Hospital admission – previous 2 months	☐ No	☐ Yes	Details:
	COVID-19 previous positive	☐ No	☐ Yes	Date:
	Current COVID-19 close contact	☐ No	☐ Yes	Details:
	If previous positive COVID-19 describe severity of symptoms	Details:		
	MRSA / Golden Staph	☐ No	☐ Yes	Details:
	VRE	☐ No	☐ Yes	Details:
	HIV / AIDS / Hepatitis	☐ No	☐ Yes	Details:
Creutzfeldt – Jakob Disease	Pituitary Hormone Injections – before 1986	☐ No	☐ Yes	Details:
	Family history	☐ No	☐ Yes	Details:

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I CONSENT TO CANOSSA PRIVATE HOSPITAL STAFF PROVIDING THE FOLLOWING CARE (TICK TO INDICATE CONSENT):

- ☐ Medications as ordered by my medical practitioner
- ☐ Physical care including assistance with activities of daily living and mobility, other care, and assistance reasonably incidental to the above
- ☐ Physical therapies

I UNDERSTAND THAT I AM RESPONSIBLE FOR THE FOLLOWING:

- ☐ Providing accurate information regarding my current private health insurance
- ☐ Complete payment of all accounts associated with this admission
- ☐ In the event of an emergency I understand that I may need to be transferred to another medical facility for ongoing treatment as medical staff are not on site 24 hours/day.
- ☐ I hereby release the hospital and hospital staff from all liability for any adverse results arising if I remove myself/ this patient from the hospital at my own insistence and against the advice of the hospital staff and medical practitioner.
- ☐ If applicable, I agree to provide a copy of my Advanced Health Directive to Canossa Private Hospital. In the event I do not provide this document I accept the hospital may not have knowledge of my health decisions.

USE OF MY PERSONAL INFORMATION

- ☐ In some cases the Australian Privacy Principles prohibit the use of personal information that Canossa Private Hospital collects and holds, if you do not consent to the use of such information. You are under no obligation to provide consent to the use of your personal information.
  If you provide consent, the information will be used in a format where your identity will be clear in any material generated. If you do not consent, we will respect your wishes and will inform you if this affects our ability to provide care and services to you. Our privacy policy is available on our website canossahospital.org.au and is available to view at our facility.

I CONSENT TO THE FOLLOWING:

- ☐ The sharing of relevant medical and personal information to other medical practitioners or institutions who may treat me in the future
- ☐ Notify next of kin of treatment outcomes
- ☐ To obtain consent to necessary treatment when I am not able to provide such consent
- ☐ To inform visitors of, and forward telephone enquiries and calls to my location within the facility
- ☐ Medical, nursing, allied health and students accessing my health records for the purpose of education and training
- ☐ Canossa Private Hospital to access to my Health Fund of which I am a member, if requested by the Health Fund to do so
- ☐ Canossa Private Hospital communicating promotional material and special events to me

I (insert name)

have read the above and certify that the information I have provided is true and correct at the time of completing the documents. I consent to all statement unless I have documented NO beside the applicable statement.

NAME:	SIGNATURE:	DATE:

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