CANOSSA PRIVATE HOSPITAL	**HOSPITAL ADMINISTRATION SECTION ONLY**
HEALTH ASSESSMENT	*FAMILY NAME:* *UR:*
	FIRST NAMES:
	DATE OF BIRTH: *GENDER:*
Email: theatrereception@canossa.org.au **Ph: 07 33755107** **Fax: 07 33754902**	*AFFIX PATIENT LABEL HERE*

Procedure:

Patient Medical & Surgical History

Physical	DOB: ______________ Age: ______________			
	Height: ______________cm Weight: ______________kgs			
Cardiac	High Blood Pressure	Yes ☐	No ☐	
	High Cholesterol	Yes ☐	No ☐	
	Anemia	Yes ☐	No ☐	
	Chest Pain / Angina	Yes ☐	No ☐	
	Heart Attach / AMI	Yes ☐	No ☐	If Yes Date: ______________
	Blood Clot (DVT) Lungs / Legs	Yes ☐	No ☐	
	Rheumatic Fever	Yes ☐	No ☐	
	Do you smoke	Yes ☐	No ☐	If Yes: How many ______________
Endocrine	Diabetes	Yes ☐	No ☐	
	If Yes: Type 1 ☐ Type 2 ☐	IDDM Insulin Dependent ☐	NIDDM Diet / Insulin / Tablet ☐	
Respiratory	Chronic Obstructive Airway Disease	Yes ☐	No ☐	
	Asthma	Yes ☐	No ☐	
	Bronchitis	Yes ☐	No ☐	
	Hay Fever	Yes ☐	No ☐	
	Pneumonia	Yes ☐	No ☐	
	Shortness of Breath	Yes ☐	No ☐	
	Cough / Cold / Sore Throat	Yes ☐	No ☐	
Vascular	Peripheral Vascular Disease	Yes ☐	No ☐	
	Varicose Veins	Yes ☐	No ☐	
	Poor Circulation to Hands / Feet	Yes ☐	No ☐	
	Pressure Ulcer Sore / Venus Ulcer	Yes ☐	No ☐	If Yes: Location ______________
GI	Indigestion / Reflux	Yes ☐	No ☐	
	Bowel Disease	Yes ☐	No ☐	
	Incontinence Issues	Yes ☐	No ☐	If Yes: Bowel ☐ Bladder ☐
	Kidney Disease	Yes ☐	No ☐	
	Liver Disease	Yes ☐	No ☐	
Neurological	Stroke	Yes ☐	No ☐	
	TIA (Trans Ischemic Attack)	Yes ☐	No ☐	
	Epilepsy / Seizure	Yes ☐	No ☐	
	Sleep Disorders	Yes ☐	No ☐	
	Fainting / Dizziness	Yes ☐	No ☐	
	Falls History	Yes ☐	No ☐	If Yes Please State ______________
	Neck or Back Issues	Yes ☐	No ☐	If Yes Please State ______________
	Mental Health / Stress Conditions	Yes ☐	No ☐	If Yes Please State ______________
	Additional support during admission	Yes ☐	No ☐	If Yes Please State ______________
Previous Surgery	Anaesthetic Issues (include family issues)	Yes ☐	No ☐	If Yes Please State ______________
	Joint Replacement	Yes ☐	No ☐	If Yes: Location ______________
	Heart / Valve Replacement	Yes ☐	No ☐	If Yes: Year ______________
	Angioplasty / Cardiac Stent	Yes ☐	No ☐	
	Cardiac Pacemaker / Defibrillation	Yes ☐	No ☐	
	Renal Stent	Yes ☐	No ☐	
	Lens Implant	Yes ☐	No ☐	

HEALTH ASSESSMENT

	Skin Cancer Yes ☐ No ☐ If Yes Type / Location ______________________
	Other Implants Yes ☐ No ☐ If Yes Please State ______________________ List other previous surgery details: ______________________
Allergies & Sensitivity	Tapes / Lotions Yes ☐ No ☐ Latex or Rubber Yes ☐ No ☐ Food (Kiwi Fruit, Banana etc) Yes ☐ No ☐ If Yes Please Describe ______________________ Medications Yes ☐ No ☐ If Yes Please List ______________________ Other Allergies Yes ☐ No ☐ If Yes Please List ______________________
Other	Pregnant Yes ☐ No ☐ N/A ☐ Eczema/Dermatitis/Psoriasis Yes ☐ No ☐ If Yes Please State______________________ Arthritis Yes ☐ No ☐ Mobility Aids Yes ☐ No ☐ Vision Impaired Yes ☐ No ☐ Hearing Impaired / Aids Yes ☐ No ☐ Dental Appliance (cap / crowns / bridge) Yes ☐ No ☐ If Yes Please State ______________________ Fragile Skin Yes ☐ No ☐ Bruise / Bleed Easily Yes ☐ No ☐ If Yes Please State ______________________ Blood Transfusion Yes ☐ No ☐ Blood Transfusion Reaction Yes ☐ No ☐ If Yes Please Describe______________________ Alcohol Intake Yes ☐ No ☐ If Yes Amount ________ Frequency____________ Recreational Drugs Yes ☐ No ☐ If Yes Type__________ Date last intake _________
Current Medication	Blood Thinners Yes ☐ No ☐ If Yes Please Describe ______________________ Blood Thinners Ceased Yes ☐ No ☐ If Yes Date______________________ Steroids / Cortisone Yes ☐ No ☐ If Yes Please Describe ______________________ Steroids / Cortisone Ceased / Last Dose ______________________ Cytotoxic Medication Yes ☐ No ☐ If Yes Please Describe ______________________ Cytotoxic Medication Ceased / Last Dose ______________________ Prescribed Medication List ______________________ Non Prescribed / Herbal Medication List ______________________
Infections Assessment	Overseas Travel within previous 10 days Yes ☐ No ☐ If Yes Please State __________ Inpatient another Hospital within previous 2 months Yes ☐ No ☐ If Yes Please State __________ MRSA / Golden Staph (Multi / Methicillin Resistant Staphylococcus Aureus) Yes ☐ No ☐ If Yes Date ____________ VRE (Vancomycin Resistant Enterococci) Yes ☐ No ☐ If Yes Date ____________ HIV / AIDS Yes ☐ No ☐ If Yes Date ____________ Hepatitis Yes ☐ No ☐ If Yes Date ____________ Pituitary Hormone Injection Before 1986 Yes ☐ No ☐ Neurosurgery Before 1990 Yes ☐ No ☐ If Yes Provide Details _______ Family History Creutzfeldt-Jakob Disease Yes ☐ No ☐ If Yes Provide Details ________

I ______________________ have read the above and certify that the information given is correct and true to the best of my ability. **Signature:**______________________ **Date:**____________