PRE-ADMISSION HEALTH QUESTIONNAIRE

MR7

ALLERGIES		Staff use
Do you have any allergies? ☐ Yes ☐ No (If yes please tick appropriate box and name allergies and give details)		Entered on IBA ☐ ___/___/___
☐ Drug or Natural Remedy Allergy	☐ Latex / Rubber Allergy	
☐ Adhesive Tapes Allergy	☐ Food Allergy	
☐ Lotions Allergy	☐ Other Allergy	

PATHOLOGY / X-RAYS OR OTHER TEST RESULTS	Staff use
Has your surgeon ordered blood tests / pathology / autologous blood for **THIS admission** ☐ Yes ☐ No Name of Pathology Service: ________________ Date of test ________ Have you had a recent ECG / Echocardiogram? ☐ Yes ☐ No Have X-rays been taken for this admission? ☐ Yes ☐ No If Yes – please make sure you bring them with you	Results available? ☐ In File ☐ Online ☐ Not available ☐ With Patient ☐ With Doctor

GENERAL MEDICAL HISTORY	YES	NO (Please Tick)	Comments & Further Information	
Heart Disease including Heart Attack / Angina			Details/Date:	
(Please Circle) High Blood Pressure High Cholesterol			Details: Name of treating Dr:	
(Please Circle) Peripheral Vascular Disease palpitation, irregular heart beat / heart murmur				
(Please Circle) Implanted devices / prosthesis (eg joint / heart valve / lapband / stents / stimulators/ shunts/eye lens/other Pacemaker – last checked ___ / ___ / ___			Type & brand of implant: Is surgeon aware? ☐ Yes ☐ No Bring ID information if applicable	Ward / Theatre Notified ☐ __/__/__
Diagnosed Sleep Apnoea CPAP ☐ Mouth Guard ☐			Bring CPAP Machine to hospital Mouth Guard ☐	
(Please Circle) Asthma / bronchitis / emphysema / shortness of breath / hay fever / pneumonia / TB			Treatment (Please Tick) ☐ Oral Steroids ☐ Puffers ☐ Nebulisers ☐ Home Oxygen Please bring all Asthma medications	
Anaesthetic Reactions			Details	Anaesthetic referral ☐ __/__/__
Family history of anaesthetic reactions				
Problems with extending neck fully?				
Diabetes Type 1 ☐ Type 2 ☐			Controlled by ☐ Diet ☐ Tablet ☐ Insulin ☐ Pump	
Do you have instructions how to manage your diabetes on the day of surgery?			Specialist details:	
(Please Circle) Blood Disorders / bleeding problems / bruise easily / anaemia			Details	
Blood clots in legs			Specify	VTE Assessment ☐ PAC ☐ On Admission
Blood clots in lungs			Is Surgeon aware? ☐ Yes ☐ No	
Blood Transfusion Blood Transfusion reaction			Date of last transfusion ___ / ___ / ___ Type of reaction	
Arthritis			Details:	
Infectious diseases: HIV / sexual / hepatitis or other infections			Specify Treatment:	Infection Control ☐ __/__/__
Elimination issues: bowel or bladder problems / incontinence / stoma therapy			Specify	
(Please Circle) Skin conditions – existing wounds / fistula / pressure areas / ulcers / broken skin or reddened due to friction or pressure			Details and current treatment:	Pressure Ulcer Assessment ☐ By PAC ☐ On Admission