Central Sydney
Private Hospital
悉尼中央私立醫院
part of sms centres of surgery

Admissions Office
Level 5, Sussex Centre 401 Sussex Street
Haymarket NSW 2000
Email: bookings@centralsydneyprivatehospital.com.au
Ph: 9281 3822 Fax: 9281 5922

Place ID Label Here

PATIENT HISTORY FORM

To be completed by Patient and forwarded to admission office two weeks prior to admission

To be completed by Patient or Carer.

Please *PRINT* clearly. Your responses are valuable in planning your admission and caring for you during your stay.

ADMISSION DETAILS

Please specify the reason for your admission

Is this admission due to a past or present injury?

☐ Yes ☐ No *(If yes please provide further information below)*

Cause of Injury:

_____

Place: _____ Date: / /

Have you been instructed to cease this medication?

☐ Yes ☐ No *(If yes please provide further information below)*

Date last taken / / or still taking ☐ Yes

Have you taken any steroids or cortisone tablets/injections in the last 6 months? ☐ Yes ☐ No

(If yes please provide further information below)

Name of Medication:

_____

Date last taken / / or still taking ☐ Yes

Are you taking any other prescription or non-prescription?

(If yes please provide further information below)

Medication? List the medications you currently take (include name of medication). Please bring all medications you are currently taking with you on admission in the original packaging including herbal medicines.

☐ Yes ☐ No

- Medication: _____
  for Treatment of _____
  _____
  Frequency _____ Dose _____
- Medication: _____
  for Treatment of _____
  _____
  Frequency _____ Dose _____
- Medication: _____
  for Treatment of _____
  _____
  Frequency _____ Dose _____
- Medication: _____
  for Treatment of _____
  _____
  Frequency _____ Dose _____
- Medication: _____
  for Treatment of _____
  _____
  Frequency _____ Dose _____

GENERAL MEDICAL CONDITION

Diabetes ☐ Yes ☐ No

If yes, what type? ☐ Type 1 ☐ Type 2

Managed by: ☐ Insulin injection ☐ Tablet ☐ Diet

What medication do you take? _____

Cancer ☐ Yes ☐ No Site: _____

Stroke ☐ Yes ☐ No

Date: / / Residual problems: _____

High blood pressure ☐ Yes ☐ No

Heart attack/chest pain/angina ☐ Yes ☐ No

Date: / /

Palpitations/irregular heart beat/heart murmur ☐ Yes ☐ No

Pacemaker ☐ Yes ☐ No

Make: _____ Model: _____

Last checked: / /

Prosthetic heart valve ☐ Yes ☐ No Type: _____

Rheumatic Fever ☐ Yes ☐ No

Tendency to bleed/bloodclots/DVTs/bruise easily

☐ Yes ☐ No

Arthritis ☐ Yes ☐ No

Asthma/bronchitis/pneumonia/hayfever ☐ Yes ☐ No

Liver disease/hepatitis (Specify type A, B, C) ☐ Yes ☐ No

Type: _____

Kidney/bladder problems ☐ Yes ☐ No

Hiatus hernia/gastrointestinal ulcers/bowel disorder

☐ Yes ☐ No _____

Thyroid problems ☐ Yes ☐ No

Epilepsy/fits/febrile convulsions ☐ Yes ☐ No

Depression/dementia/other mental illness ☐ Yes ☐ No

Do you require access to mental health services ☐ Yes ☐ No

Migraines ☐ Yes ☐ No

Eye disease ☐ Yes ☐ No

Female patients could you be pregnant? ☐ Yes ☐ No

Number of weeks: _____

Impairment e.g. vision, hearing, mobility ☐ Yes ☐ No

History of pressure injuries ☐ Yes ☐ No

BINDING MARGIN - NO WRITING

PATIENT HISTORY FORM

MR 4

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PREVIOUS OPERATIONS / PROCEDURES / ANAESTHETIC DETAILS

Have you had previous operations, please list dates and operations performed:

Date: / / _____
Date: / / _____
Date: / / _____
Date: / / _____
Date: / / _____
Date: / / _____

Have you or anyone in your immediate family ever had a severe reaction to an anesthetic? e.g. malignant hyperthermia

☐ Yes ☐ No Details of reaction: _____

Have you ever had a blood transfusion? ☐ Yes ☐ No

Details of reaction: _____

PROSTHESIS / AIDS / OTHERS

Glasses/Contact Lenses ☐ Yes ☐ No

Hearing aid or other hearing appliance ☐ Yes ☐ No

Body Piercing ☐ Yes ☐ No

Dentures/Caps/Crowns/Loose Teeth/wires ☐ Yes ☐ No

Artificial joints or limbs ☐ Yes ☐ No

LIFESTYLE

Have you ever smoked? ☐ Yes ☐ No

Daily amount: _____ or date ceased / /

Do you drink alcohol? ☐ Yes ☐ No

Daily amount: _____

Do you use recreational drugs? ☐ Yes ☐ No

Type: _____ Daily amount: _____

How Often: _____

Do you require a special diet? ☐ Yes ☐ No

Type of Diet: _____

Do you exercise? ☐ Yes ☐ No How often? _____

Do you require an interpreter? ☐ Yes ☐ No

Language spoken at home: _____

Do you have someone to interpret for you? ☐ Yes ☐ No

Name of Person/ Relation: _____

Have you a fear of falling or have fallen within the last 6 months? ☐ Yes ☐ No

Do you use mobility aids ☐ Yes ☐ No Type: _____

Have you experienced fainting or dizziness in the last 3 months?

☐ Yes ☐ No

ALLERGIES

Do you have any allergies to medications, food, sticky plaster, latex/ rubber (e.g. balloons, gloves) or other substances?

*Allergies: ☐ Gluten ☐ Seafood ☐ Nuts ☐ Seeds

*Others (Please provide details)

☐ Yes ☐ No

_____

Specify Details and Reaction: _____

_____

INFECTION RISK

Have you travelled to a country with a health alert in the last 7 days

☐ Yes ☐ No _____

Do you have a fever and/or respiratory symptoms eg. cough, sore throat, runny nose ☐ Yes ☐ No _____

Have you had recent contact with patient/s diagnosed with Acute Respiratory Infections or Acute Respiratory Illness in the last 7 days (Seasonal or Pandemic) eg. COVID-19, SARs/H5N1 Influenza, either overseas or in Australia, within 7 days of onset of symptoms.

☐ Yes ☐ No

_____

_____

Have you travelled to areas of high prevalence for Acute Respiratory Infections or Acute Respiratory Illness in the last 7 days (Seasonal of Pandemic) eg. SARs/H5N1 Influenza, either overseas or in Australia, within 7 days of onset of symptoms

☐ Yes ☐ No _____

Have you ever had MRSA/Golden Staph, VRE or ESBL

☐ Yes ☐ No _____

Do you have any wounds or breaks on your skin

☐ Yes ☐ No _____

Do you have any other conditions or infections

☐ Yes ☐ No _____

Have you had vomiting and diarrhea in the past 48 hours/ 72 instead

☐ Yes ☐ No _____

QUESTIONS RELATING TO CREUTZFELDT JAKOB DISEASE

Have you had a dura mater graft between 1972 - 1989?

☐ Yes ☐ No _____

Do you have a family history of 2 or more relatives with CJD or other unspecific progressive neurological disorder?

☐ Yes ☐ No _____

Have you received human pituitary hormones (growth hormones, gonadotrophins) prior to 1985?

☐ Yes ☐ No _____

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DISCHARGE PLANNING

This information is necessary in order to help you plan a safe return to home after discharge. ALL patients to complete

Are you over 80 years of age? ☐ Yes ☐ No

Do you live alone? ☐ Yes ☐ No

I have no one to look after me after discharge. ☐ Yes ☐ No

or, name of person Relationship: _____

_____

Are you solely responsible for the care of another person at home? ☐ Yes ☐ No

Do you currently receive community support services?
☐ Yes ☐ No _____

Do you require assistance with any aspect of day to day living?
☐ Yes ☐ No

_____

_____

Where do you plan to go after discharge?

_____

_____

How will you get there?

_____

_____

Do you have any concerns about how you will manage at home after discharge?

_____

_____

_____

_____

Name of person completing form: _____

_____

Relationship: _____ Date: / /

NURSES USE ONLY

Patient history form reviewed by Pre-admission / admitting nurse:
☐ Yes ☐ No

Name of admitting nurse: _____

Designation: _____

Signature: _____

Date: / / Time: _____

Patient history form reviewed by Ward Staff
☐ Yes ☐ No

Name of ward nurse: _____

Designation: _____

Signature: _____

Date: / / Time: _____

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PATIENT HISTORY FORM

MR 4

MARCH 21

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BINDING MARGIN - NO WRITING

MARCH 21