JESSIE MCPHERSON
PRIVATE HOSPITAL

246 Clayton Road, Clayton Vic 3168 Tel 9594 2776

Unit Record Number: .....

Surname .....

Given Name .....

D.O.B ..... Age ..... Sex .....

Address .....

Affix Patient Identification Label

PATIENT HISTORY FORM D

Patient's name .....

Reason for admission .....

Operation date .....

Name of Operation .....

ALLERGIES

Do you have any allergies ☐YES ☐NO

If YES please specify allergy and reaction .....

Height: ..... Weight: .....

PREVIOUS SURGERY

OPERATION / PROCEDURES	YEAR	OPERATION / PROCEDURES	YEAR

ANAESTHETIC AND MEDICATION HISTORY

ANAESTHETIC HISTORY	YES	NO	MEDICATION	YES	NO
Have you ever had an anaesthetic?	☐	☐	Have you recently taken blood thinning medication (aspirin/warfarin)?	☐	☐
Has anyone in your family had a problem with anaesthetic?	☐	☐	Have you taken any steroids or cortisone in the last 6 months?	☐	☐
Have you ever had problems with anaesthetic? If yes, please explain	☐	☐			

MEDICATIONS

Please bring your current medication with you in the original packaging.

Please list the medications you currently take / or attach list:

MEDICATION	DOSE	HOW OFTEN	MEDICATION	DOSE	HOW OFTEN

Do you take recreational drugs? ☐YES ☐N

Details: .....

Have you been instructed to withhold any medication prior to your admission? ☐YES ☐N

Details: .....

Have blood tests been taken for this admission? ☐YES ☐N

☐Doretevich ☐Melbourne Pathology ☐Gribbles ☐Other

Have x-rays been taken for this admission? ☐YES ☐NO

Who has the x-rays/scan? ☐With patient ☐With doctor

Please bring any x-rays/scans you have related to this admission with you.

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QUESTIONS RELATING TO CREUTZFELDT JAKOB DISEASE

	YES	NO
Have you had a Dura mater graft between 1972 - 1989?	☐	☐
Do you have a family history of 2 or more relatives with CJD or other unspecified progressive neurological disorders?	☐	☐
Have you received human pituitary hormones (growth hormones, gonadotrophins) prior to 1985?	☐	☐
Have you suffered from a recent progressive dementia (physical or mental), the cause of which has not been diagnosed?	☐	☐

DISCHARGE PLANNING

YES	NO		
☐	☐	1	Do you live alone? .....
☐	☐	2	Do you live in a rooming house or in a long term care facility? If Yes please circle: nursing home / hostel / special accommodation
☐	☐	3	Do you have responsibility for the care of others at home? If Yes please circle: sole parent / care of disabled
☐	☐	4	Do you currently require assistance with: (please circle) toileting / showering / bathing / dressing / cooking / housework / shopping
☐	☐	5	If needed will assistance be available to you when you return home?
☐	☐	6	Do you currently receive any support services? (please circle) e.g. district nursing / meals on wheels / home-help / personal care / respite care / Linkages / Community Aged Care Packages
☐	☐	7	Are you currently employed?
		8	What is your occupation? .....
☐	☐	9	Do you need a medical certificate?
☐	☐	10	How long do you expect to be in hospital? .....

Signature of Person Completing Form: ..... **Date signed:** .....

Relationship to patient (if not completed by the patient) .....

Please deliver/post this form as soon as possible to:

Jessie McPherson Private Hospital
246 Clayton Road
Clayton VICTORIA 3168

Thankyou for completing this form.

Jessie McPherson Private Hospital Patient Care Coordinator Staff use only

Screened by: ..... Date: .....

Further comments

Signature of admitting nurse: ..... **Date:** .....

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SHF00445

PATIENT HISTORY FORM D

Have you ever had any of the following:

YES	NO	HEAD & SPINE	SPECIFY
☐	☐	Stroke	
☐	☐	Parkinson's Disease	
☐	☐	Epilepsy / seizures	
☐	☐	Migraines / headaches	
☐	☐	Sleeping problems	
☐	☐	Depression / mental illness	
☐	☐	Swallowing / speech difficulties	
☐	☐	Other (specify)	

YES	NO	HEART & CIRCULATION	SPECIFY
☐	☐	Family history of heart problems	
☐	☐	Angina / chest pain	
☐	☐	Heart attack	
☐	☐	High blood pressure	
☐	☐	High cholesterol	
☐	☐	Heart failure	
☐	☐	Irregular heart rate / palpitations	
☐	☐	Pacemaker / AICD insitu	Date inserted_____ Type_____
☐	☐	Other (specify)	

YES	NO	LUNGS & BREATHING	SPECIFY
☐	☐	Pneumonia / bronchitis	
☐	☐	Asthma	
☐	☐	Airways disease eg. emphysema	
☐	☐	Sleep apnoea	
			CPAP ☐YES ☐NO Bring CPAP machine in
☐	☐	Do you have oxygen at home	
☐	☐	Recent cold / cough / sputum	
☐	☐	Other (specify)	

YES	NO	METABOLIC / HORMONAL	SPECIFY
☐	☐	Diabetes / Insulin / Injections / Tablets	
☐	☐	Thyroid disorder	
☐	☐	Liver disease / hepatitis	
☐	☐	Other (specify)	

YES	NO	KIDNEY / REPRODUCTIVE	SPECIFY
☐	☐	Bladder problems / infections	If incontinent, specify aids used:_____
☐	☐	Kidney problems	
☐	☐	Prostate problems	
☐	☐	Gynaecological problems	If female, currently pregnant? ☐YES ☐NO
☐	☐	Other (specify)	

MRD04(II)A
04/12

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PATIENT HISTORY FORM D

YES	NO	GASTROINTESTINAL	SPECIFY
☐	☐	Bowel problems	If incontinent, specify aids used:_____
☐	☐	Stoma - ileostomy / colostomy	
☐	☐	Constipation	Regular aperients_____
☐	☐	Stomach Ulcer	
☐	☐	Hiatus hernia / reflux	
☐	☐	Other conditions (specify)	
☐	☐	Usual diet (specify)	
☐	☐	Other dietary requirements: (specify)	

YES	NO	BLOOD	SPECIFY
☐	☐	Problems with bleeding or clotting	
☐	☐	Previous blood transfusion	Date _____ If yes, any reaction?
☐	☐	Other problems (specify)	

YES	NO	MUSCLE & BONES	SPECIFY
☐	☐	Osteoarthritis	
☐	☐	Osteoporosis	
☐	☐	Fractures	
☐	☐	Previous Joint Replacement	
☐	☐	Other problems (specify)	

YES	NO	INFECTIOUS	SPECIFY
☐	☐	Any infectious diseases eg. HIV, AIDS, VRE, MRSA	

YES	NO	OTHER	SPECIFY
☐	☐	Do you have any health problems not already mentioned	eg. Cancer, Mental health, Chronic Pain

YES	NO	PROSTHESIS /AIDS/OTHERS	
☐	☐	Glasses / Contact Lenses	Comments/Details _____
☐	☐	Hearing aid or other hearing appliance	Comments/Details _____
☐	☐	Dentures / caps / crowns / loose teeth	Comments/Details _____
☐	☐	Do you use mobility aids eg. Walking stick, frame etc	_____

YES	NO	LIFESTYLE
☐	☐	Have you ever smoked Daily amount _____ Date ceased _____
☐	☐	Do you drink alcohol Average Daily amount _____ Date ceased _____
☐	☐	Do you have an enduring power of health attorney – health and medical guardian
		Name of person _____ Contact Number _____