THE AVENUE HOSPITAL

40 The Avenue, Windsor, Victoria 3181
Telephone 61 3 9529 7377 Facsimile 61 3 9529 6815

PATIENT HISTORY

PATIENT TO COMPLETE

Patient Surname: ....
Given Names: ....
Date of Birth: .... Doctor: ....
Patients Contact Number: ....
Reason for admission: ....
Date of admission: ....

What is your height: Weight: Blood group (if known):

ADMISSION DETAILS	YES	NO	IF YES, PLEASE ADD COMMENTS/DETAILS
Have you had any blood tests taken?			Date: Company:
Have you donated your own blood?			Number of units:
Have you had any Xrays taken?			Company:

ALLERGIES Have you had any reaction to the following:	YES	NO	IF YES, PLEASE ADD COMMENTS/DETAILS
☐ Medications			
☐ Tapes ☐ Lotions ☐ Food			
☐ Latex / rubber			

MEDICATIONS:	YES	NO	IF YES, DATE LAST TAKEN / DATE TO BE CEASED
Have you recently taken the following medications?			
☐ Warfarin			
☐ Blood thinning/Aspirin based			
☐ Anti inflammatory/Arthritis			
☐ Cortisone/Steroids			

List all medication/tablets/puffers/vitamins/herbal medicine that you currently take (please attach separate list if not enough room to list all)

Medication	Dose	Frequency	Medication	Dose	Frequency

CURRENT & PAST MEDICAL HISTORY:	YES	NO	IF YES, PLEASE ADD COMMENTS/DETAILS
Have you had or do you have any of the following?:			
Diabetes – ☐ Type 1 ☐ Type 2 ☐ Unsure			Managed with:
☐ High blood pressure ☐ Low blood pressure			
☐ Heart attack ☐ Angina ☐ Chest pain			
☐ Palpitations ☐ Irregular heart beat			
☐ Heart murmur ☐ Atrial fibrillation			
☐ Pacemaker ☐ Heart valve replaced			Bring pacemaker details with you/or attach
☐ Heart surgery			
☐ Rheumatic fever			
☐ Asthma ☐ Bronchitis ☐ Hayfever			
☐ Pneumonia ☐ TB			
☐ Stroke ☐ TIAs			
☐ Tendency to bleed/bruise ☐ Anaemia ☐ Blood Disorder			
☐ Blood clot in legs ☐ Blood clot in lungs			
☐ Liver disease ☐ Hepatitis (A, B, C)			
Are you at increased risk of HIV and Hepatitis?			
☐ Recent cold ☐ Flu ☐ Other infection			
☐ Kidney problems			Describe:
☐ Bladder problems (eg. difficulty passing urine, incontinence etc.)			
☐ Bowel problems ☐ Gastric ulcers ☐ Hiatus hernia			
☐ Sleep disorder ☐ Snoring ☐ Sleep Apnoea			
☐ Epilepsy ☐ Fits			
☐ Depression ☐ Other mental illness:			Describe:
☐ Dementia ☐ Alzheimers			
Female patients: Could you be pregnant?			
Other medical conditions (eg. cancer, family history of cancer, arthritis ect.)			

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PREVIOUS OPERATIONS / PROCEDURES / HOSPITAL STAYS OR VISITS

Date ____/____/____ ....

Date ____/____/____ ....

Date ____/____/____ ....

Date ____/____/____ ....

PAST ANAESTHETIC DETAILS	YES	NO	IF YES, PLEASE ADD COMMENTS/DETAILS
Have you/your family ever reacted to an anaesthetic?			
Have you ever had a blood transfusion?			
CLASSICAL CREUTZFELDT JAKOB DISEASE (cCJD):	**YES**	**NO**	**IF YES, PLEASE ADD COMMENTS/DETAILS**
Have you had a Dura Mater Graft (prior to 1989?)			
Do you have a family history of two or more immediate relatives with cCJD or other unspecified progressive neurological disorder?			
Have you / has the patient suffered from a recent progressive dementia (physical or mental) the cause of which has not been diagnosed?			
Have you received human pituitary hormones prior to 1985?			
Have you been involved in a "Look Back' study for cCJD or are in the possession of a "Medical in Confidence Letter" regarding risk of cCJD?			
SARS / AVIAN FLU	**YES**	**NO**	**IF YES, PLEASE ADD COMMENTS/DETAILS**
Has MR 160 Admission / SARS Questionnaire been completed?			
PROSTHESIS / AIDS	**YES**	**NO**	**IF YES, PLEASE ADD COMMENTS/DETAILS**
Visual impairment			☐ Glasses ☐ Contacts
Hearing impairment			☐ Hearing Aids ☐ Other
Dentures			☐ Top ☐ Bottom
Teeth			☐ Caps ☐ Crowns ☐ Loose teeth
Implants			☐ Plates ☐ Pins ☐ Joints **Location:**
Walking aids			☐ Frame ☐ Crutches ☐ Stick
LIFESTYLE	**YES**	**NO**	**IF YES, PLEASE ADD COMMENTS/DETAILS**
Have you ever smoked?			Amount: Date ceased:
Alcohol/recreation drugs			Amount: Type:
Special diet required			
Do you require an interpreter?			Organised with:
PLANNING FOR YOUR SAFE DISCHARGE	**YES**	**NO**	**IF YES, PLEASE ADD COMMENTS/DETAILS**
Have you experienced fainting or dizziness recently?			
Do you live alone?			
Are you the carer of another person?			
Do you currently receive community services?			Name of service(s):
Do you require assistance with any aspect of day to day living?			
Will you need us to organise any support services following your discharge?			Name of service(s):

Who will care for you after discharge from Hospital? .... Relationship: ....

Where do you plan to go after discharge? .... How will you get there? ....

How long do you expect to stay in Hospital? ....

Do you have concerns or questions about coming into Hospital? ....

Person completing this form? ☐ Patient ☐ Relative ☐ Nurse ☐ Other ....

NURSE TO COMPLETE

☐ IF YES TO ANY RED HIGHLIGHTED BOX, PLEASE COMPLETE ADDITIONAL FORM AND / OR MAKE APPROPRIATE REFERRALS

☐ ALL INFORMATION ON BRADMAR STICKER HAS BEEN CONFIRMED CORRECT WITH PATIENT OR SIGNIFICANT OTHER

Pre–Admission Nurse:

....

Signature Designation Print Initials Date Time (Hrs)

Admitting Nurse:

....

Signature Designation Print Initials Date Time (Hrs)

Nursing Notes ....

BINDING MARGIN - DO NOT WRITE