

HEALTH ASSESSMENT FORM

Surname: _____

First Name: _____

U.R. Name: _____

Ward: _____ Bed: _____

Please affix patient's identification label

Procedure:

Patient Medical / Surgical History

Physical	Age	Height cm	Weight kg	BMI
Cardiac	High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rheumatic Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>
	High Cholesterol	Yes <input type="checkbox"/> No <input type="checkbox"/>	Clot lungs/legs (DVT/PE)	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Do you smoke? No. per day	Yes <input type="checkbox"/> No <input type="checkbox"/>	Anaemia (current)	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Heart Attack / MI Date	Yes <input type="checkbox"/> No <input type="checkbox"/>	Chest pain / Angina	Yes <input type="checkbox"/> No <input type="checkbox"/>
Endocrine	Diabetes Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> <input type="checkbox"/> IDDM Insulin Dependent <input type="checkbox"/> NIDDM Diet/insulin/tablet	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you have a hip/ heart valve replacement angioplasty/cardiac renal/stent/pacemaker defibrillator/lens implant	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Respiratory	Chronic obstructive airway Asthma/Bronchitis/Hay fever Sleep Apnoea	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	Shortness of breath Pneumonia/Tuberculosis Do you have a cough, cold or sore throat?
Vascular	Peripheral Vascular disease (varicose veins, poor circulation to hands or feet)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pressure Ulcer Where:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Intestinal Tract	Indigestion/Reflux	Yes <input type="checkbox"/> No <input type="checkbox"/>	Bowel disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Kidney disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Incontinence issues	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Liver disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Bowel <input type="checkbox"/> Bladder <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Neurological	Stroke	Yes <input type="checkbox"/> No <input type="checkbox"/>	Back or neck problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Epilepsy or other fits	Yes <input type="checkbox"/> No <input type="checkbox"/>	Stress/mental health conditions	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Falls	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sleep disorders	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Faint/dizziness	Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you any reason to believe you are in a high risk group for hepatitis or HIV (AIDS virus)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Previous Surgery	Cancer:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Any other medical conditions	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Site/s: Eczema/Dermatitis/Psoriasis	Yes <input type="checkbox"/> No <input type="checkbox"/>		
	Arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>		
	Vision/Hearing/Mobility aides	Yes <input type="checkbox"/> No <input type="checkbox"/>		
	List details of previous surgery and dates:			
Other Notes				

	Have you or a member of your family ever had problems with either local or general anaesthetics? Details:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you tend to bleed or bruise easily?	Yes <input type="checkbox"/> No <input type="checkbox"/>
			Fragile skin	Yes <input type="checkbox"/> No <input type="checkbox"/>
			Females; are you pregnant?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Have you ever had a blood transfusion?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you wear a dental appliance, cap, plate, crown or bridge?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Have you ever had a reaction?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Lifestyle	Do you drink alcohol? Daily intake:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you or have you used recreational drugs?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Medication	Have you ever had any blood thinning drugs in the last week?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you take any un-prescribed drugs or other substances?	Yes <input type="checkbox"/> No <input type="checkbox"/> Details:
	Date ceased: Examples include Aspirin, Cartia, Warfarin, Plavix, Assasantin, Heparin, Apixaban, Rivaroxaban, Pradaxa, Prasugrel, Ticagrelor Are you taking any cytotoxic/chemotherapy drugs	Yes <input type="checkbox"/> No <input type="checkbox"/>	In particular; fish oil, garlic, echinacea capsules Have you had any cortisone/steroids in the past 3 months? If yes, state either tablets, injection or cream:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Current Medication	Drugs - attach list if necessary	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Allergies	Do you have any allergies or sensitivity to tapes, lotions, food (e.g. Kiwi Fruit, Banana), Latex or rubber?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Details:	
	Do you have allergies to drugs?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Details:	
	Do you have any other allergies?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Details:	
CJD Risk Screening	Do you have a family history of 2 or more first degree relatives with Creutzfeldt-Jakob Disease or other undiagnosed neurological illness?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Did you undergo surgery on the brain (neurosurgery) before 1990?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	To your knowledge did you receive pituitary hormone injections before 1986?	Yes <input type="checkbox"/> No <input type="checkbox"/>	What type of operation was performed and who was the surgeon/hospital?	
Infectious Assessment	Do you have Multi/Methicillin Resistant Staphylococcus Aureus (MRSA/Golden Staph) or Vancomycin Resistant Enterococci (VRE) infection or any other communicable disease diagnosed within the last 14 days?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you travelled overseas in the past 10 days?	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Details:	Have you been an inpatient in another hospital in the last 2 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>
I have carefully read all the above and I certify that the information I have given is correct and true to the best of my ability. Signature: _____ Print Name: _____ Date: _____				