

CDSC

Tel 07 3375 7777

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Canossa Day Surgery Centre

eMail admin@cdsc.com.au

Place Patient ID LABEL here.

Surgery Booking details:

Date of admission:	Surgeon:
Procedure:	

Patient details:

Title	Family Name	Given Name
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Do you consent to the hospital communicating with your General Practitioner if required? yes no

Doctor's Name:	Practice Name:
Address:	Telephone:

Patient Medical History (to be completed by patient or GP):

Physical	Height	cm	Weight	kg
Previous Surgery	List details of previous surgery and dates:			
Cardiac	Hypertension/high blood pressure	<input type="checkbox"/> yes <input type="checkbox"/> no	Rheumatic fever	<input type="checkbox"/> yes <input type="checkbox"/> no
	High Cholesterol	<input type="checkbox"/> yes <input type="checkbox"/> no	Blood clot on lungs/legs (DVT)	<input type="checkbox"/> yes <input type="checkbox"/> no
	Do you smoke? Number of cigarettes per day:	<input type="checkbox"/> yes <input type="checkbox"/> no	Anemia	<input type="checkbox"/> yes <input type="checkbox"/> no
	Heart attack / AMI Date	<input type="checkbox"/> yes <input type="checkbox"/> no	Chest pain / Angina	<input type="checkbox"/> yes <input type="checkbox"/> no
	Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> IDDM Insulin Dependent <input type="checkbox"/> NIDDM Diet controlled, insulin, tablet	<input type="checkbox"/> yes <input type="checkbox"/> no	Do you have a joint or heart valve replacement, angioplasty / stent, pacemaker/defibrillator or eye implant	<input type="checkbox"/> yes <input type="checkbox"/> no
Respiratory	Chronic obstructive airway disease	<input type="checkbox"/> yes <input type="checkbox"/> no	Shortness of breath	<input type="checkbox"/> yes <input type="checkbox"/> no
	Asthma/Bronchitis/Hay fever	<input type="checkbox"/> yes <input type="checkbox"/> no	Tuberculosis	<input type="checkbox"/> yes <input type="checkbox"/> no
	Pneumonia	<input type="checkbox"/> yes <input type="checkbox"/> no	Have you recently had a cough, cold or sore throat?	<input type="checkbox"/> yes <input type="checkbox"/> no
Vascular	Peripheral Vascular Disease	<input type="checkbox"/> yes <input type="checkbox"/> no	Pressure Ulcer Where:	<input type="checkbox"/> yes <input type="checkbox"/> no
GIT/GUT	Indigestion or reflux	<input type="checkbox"/> yes <input type="checkbox"/> no	Hepatitis or jaundice	<input type="checkbox"/> yes <input type="checkbox"/> no
	Kidney disease	<input type="checkbox"/> yes <input type="checkbox"/> no	Liver disease	<input type="checkbox"/> yes <input type="checkbox"/> no
Neuro	Stroke	<input type="checkbox"/> yes <input type="checkbox"/> no	Back or neck problems	<input type="checkbox"/> yes <input type="checkbox"/> no
	Epilepsy or other fits	<input type="checkbox"/> yes <input type="checkbox"/> no	Stress related/mental health conditions	<input type="checkbox"/> yes <input type="checkbox"/> no
	Fainting/Dizziness	<input type="checkbox"/> yes <input type="checkbox"/> no	Sleep disorders	<input type="checkbox"/> yes <input type="checkbox"/> no
Other	Cancer Type: Site/s:	<input type="checkbox"/> yes <input type="checkbox"/> no	Have you had any reason to believe that you are in a high risk group for hepatitis or HIV (AIDS virus)?	<input type="checkbox"/> yes <input type="checkbox"/> no
	Arthritis	<input type="checkbox"/> yes <input type="checkbox"/> no	Any other medical conditions	<input type="checkbox"/> yes <input type="checkbox"/> no
	Eczema/Dermatitis/Psoriasis	<input type="checkbox"/> yes <input type="checkbox"/> no		

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Do not write in this space.

Other	Have you or a member of your family ever had any problems with either local or general anaesthetics? Details:	<input type="checkbox"/> yes <input type="checkbox"/> no	Do you tend to bleed or bruise easily? Details:	<input type="checkbox"/> yes <input type="checkbox"/> no
	Have you ever had a blood transfusion? If yes, have you ever had a reaction?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no	Females: are you pregnant? Do you wear a dental appliance, cap, plate, crown or bridge?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no
Lifestyle	Do you drink alcohol? Daily intake:	<input type="checkbox"/> yes <input type="checkbox"/> no	Do you use or have used in the past year any recreational drugs? Details:	<input type="checkbox"/> yes <input type="checkbox"/> no
Medication	Have you had any aspirin in the last week? How many and when:	<input type="checkbox"/> yes <input type="checkbox"/> no	Do you take any unprescribed drugs or other substances? Details: In particular: fish oil, garlic capsules	<input type="checkbox"/> yes <input type="checkbox"/> no
	Are you currently on Warfarin or anti-platelet drugs?	<input type="checkbox"/> yes <input type="checkbox"/> no	Have you had any cortisone / steroids in the past 3 months If yes, state whether tablets, injection or cream:	<input type="checkbox"/> yes <input type="checkbox"/> no
Current Medication	Drug		Dose	Frequency
Allergies	Do you have any allergies to tapes, lotions, food (e.g. Kiwi Fruit, banana), Latex or Rubber?	<input type="checkbox"/> yes <input type="checkbox"/> no	Details:	
	Do you have any allergies to drugs?	<input type="checkbox"/> yes <input type="checkbox"/> no	Details:	
	Do you have any other allergies?	<input type="checkbox"/> yes <input type="checkbox"/> no	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?	<input type="checkbox"/> yes <input type="checkbox"/> no	Did you undergo surgery on the brain (neurosurgery) before 1990?	<input type="checkbox"/> yes <input type="checkbox"/> no
	To your knowledge did you receive pituitary hormone injections before 1986?	<input type="checkbox"/> yes <input type="checkbox"/> no	What type of operation was performed and who was the surgeon/hospital?	
SARS	Have you been in contact with a person known to have a known viral or respiratory illness the last 10 days?	<input type="checkbox"/> yes <input type="checkbox"/> no	Have you travelled from overseas in the last 10 days?	<input type="checkbox"/> yes <input type="checkbox"/> no

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:



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