Sydney Adventist Hospital

PATIENT HISTORY FORM

MRN	ACN
Family Name	Given Name(s)
Date of Birth	Phone No.
Sydney contact phone no.	Mobile No.
Admission Date	Admitting Doctor

PATIENT HISTORY

Please specify reason for this admission

Is this admission the result of a past or present injury? If **yes**, Date of injury ...../...../.....		N	Y Specify cause ..... Place (e.g. school, home) .....
Endocrinology		Name of Specialist(s)	
Diabetes		N	☐ Type 1 Controlled by: ☐ Diet ☐ Injection ☐ Tablet ☐ Type 2
If you have diabetes and you monitor your blood sugar level, are your blood sugar levels generally below 8mmol/L?		N	Y
Low blood sugar		N	Y
Thyroid problems		N	Y
Cardiovascular System		Name of Specialist(s)	
Elevated cholesterol / triglycerides		N	Y
High blood pressure / hypertension		N	Y
Chest pain, angina		N	Y
Heart attack(s)		N	Y
Palpitations / heart murmur / irregular heart beat / AF		N	Y
Previous deep venous thrombosis / pulmonary embolism / varicose veins		N	Y
Artificial implants / devices / grafts	Coronary artery bypass		Y Year.....
	Coronary / vascular stent		Y Year.....
	Artificial heart valve		Y Year.....
	Pacemaker		Y Make.....Model.....Last checked ...../...../.....
	Defibrillator		Y Make.....Model.....Last checked ...../...../.....
Heart failure / Congestive cardiac failure		N	Y
Rheumatic fever / valve disease		N	Y
Other cardiac problems		N	Y Specify .....
Family history of cardiac disease		N	Y
Respiratory System		Name of Specialist(s)	
Recent cold		N	Y
Bronchitis / Asthma / Emphysema / Chronic obstructive pulmonary disease / Shortness of breath / bronchiectasis / asbestosis		N	Y Specify ..... Do you use: ☐ Nebulisers ☐ Puffers ☐ Home Oxygen
Any other lung problems		N	Y Specify .....
Gastrointestinal System		Name of Specialist(s)	
Gastric ulcer / reflux / hiatus hernia		N	Y
Jaundice		N	Y
Hepatitis		N	Y Which type?
Stoma		N	Y
Haematology		Name of Specialist(s)	
Previous blood transfusion		N	Y Reason ..... Last given .....
Anaemia		N	Y
Blood disorders / bleeding problems / bruise easily / clotting disorders		N	Y
Do you take blood thinning / arthritis / aspirin based medication / Warfarin?		N	Y Specify ..... If **yes**, What date have you been instructed to stop this medication? ...../...../..... **If you have not been instructed to stop this medication, contact your admitting doctor immediately for instructions.**

PATIENT HISTORY FORM

MR 26A

MR26AP1

Neurology	Name of Specialist(s)		
Fits / faints / funny turns / epilepsy	N	Y	
Stroke / mini stroke / TIA	N	Y	Any residual weakness? If **yes**, Type.....
Limb paralysis	N	Y	☐ Right arm ☐ Left arm ☐ Right leg ☐ Left leg
Speech / swallowing problems	N	Y	
Polio / meningitis	N	Y	Specify.....
Previous falls / unsteady on feet	N	Y	
Short term memory loss / dementia / delirium / developmental delay	N	Y	Specify..... ***NB:** If **yes**, you may be asked to provide a family member or carer who must be in attendance for the hospital stay.*

Genitourinary / Renal System	Name of Specialist(s)		
Kidney trouble / dialysis / Renal impairment	N	Y	
Stomas	N	Y	
Bladder problems	N	Y	☐ Urinary Incontinence ☐ Frequency ☐ Urgency ☐ Pain

Musculoskeletal System	Name of Specialist(s)		
Arthritis	N	Y	
Back / neck injury or problems	N	Y	
Metal plates / pins	N	Y	Specify site .....
Hip, knee or shoulder replacements	N	Y Y	Specify site ..... ☐ L ☐ R Specify site ..... ☐ L ☐ R
Other implants / devices	N	Y	Specify ..... ☐ L ☐ R

General Health & Lifestyle			
Have you ever smoked?	N	Y	Daily amount ..... Date ceased ...../ ...../ .....
Do you presently smoke?	N	Y	.....per day
Do you drink alcohol?	N	Y	.....standard drinks per day
Past history of drug dependency	N	Y	Specify .....
Do you have chronic pain?	N	Y	Specify .....
Disturbed sleep pattern / Sleep apnoea	N	Y	☐ CPAP used ☐ Sedation
Do you exercise regularly?	N	Y	
Do you have any infections?	N	Y	Specify e.g. MRSA, VRE, other .....
Do you have a current pressure area or any areas of broken skin?	N	Y	Specify .....
Depression / mental illness / anxiety attacks	N	Y	
For female patients - are you pregnant?	N	Y	.....weeks

Summary of Previous History				
Previous surgical history		N	Y	Please specify below
Eg. Coronary artery bypass, brain, liver or pancreatic surgery, hip replacements, transplants	Year	Specify		
	Year	Specify		
	Year	Specify		
	Year	Specify		
	Year	Specify		
Problems with anaesthetics (self or family)				
Malignant Hyperthermia		N	Y	If **yes**, ☐ Self ☐ Family
Other		N	Y	Specify e.g. nausea, vomiting .....
Cancer / Lymphoma / Leukaemia		N	Y	Please specify below
				Date ...../ ...../ ..... Site ..... Treatment ☐ Surgery ☐ Chemotherapy ☐ Radiotherapy
Transplants		N	Y	Specify .....

Other			
Do you, or any relatives, have Creutzfeldt-Jakob Disease (CJD)?	N	Y	If yes, staff to notify Infection Control or AHM out of hours
Do you have a 'medical in confidence' letter regarding CJD?	N	Y	
Have you had Human Pituitary Growth Hormone prior to 1986, or neurosurgery/spinal surgery prior to 1990?	N	Y	
Do you have an unexplained progressive neurological illness in the last 12 months?	N	Y	

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Prosthetics / Aids / Other

Whilst all care will be taken SAH does not accept responsibility for valuables or personal belongings. Please label where applicable.

For Surgical Centre see Theatre checklist

			N /A	Kept at own risk	Ward Storage	Taken home by: **(Signature)**
Visual aids	N	☐ Glasses ☐ Contact lenses ☐ Sight impaired ☐ Eye Prosthesis ☐ Left ☐ Right	☐ ☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	
Hearing aids	N	☐ Left ☐ Right	☐ ☐	☐ ☐	☐ ☐	
Walking aids	N	☐ Y Specify	☐ ☐	☐ ☐	☐ ☐	
Dentures	N	☐ Upper ☐ Partial ☐ Full ☐ Lower ☐ Partial ☐ Full	☐ ☐	☐ ☐	☐ ☐	
Other	N	☐ Y Specify ..... ☐ Left ☐ Right	☐	☐	☐	

Dietary Requirements

Do you have a special diet?

☐ No ☐ Yes

If **yes**, Specify .....

✻ Please document any food allergies below

Allergies & Sensitivities

Please document any known allergies or sensitivities eg. medications, latex, plants, tape.

Allergies	Sensitivities	Reaction

✻ Food allergy

Your Current Medications

Regular pharmacy: Name ..... Contact no. .....

Please record details of all your current medications, which would include tablets, capsules, puffers, patches, injections, insulins, eye drops and creams.

Consult your GP or specialist(s) if you are unsure of any details about your medications or which medications should be ceased prior to surgery.

Bring into hospital ALL current medications you are taking in their original packaging or in a sealed and labelled dose administration pack (e.g. Webster or roll sachet). Also bring in prescriptions for current medications and PBS entitlement cards.

Please note that medications in your Webster pack may be re-dispensed by SAH pharmacy as nurses are not allowed to administer medications from these packs.

Prescription Medication

Strength	Dose & Frequency (ie. how much / how often and when)	For Long Stay patients only: Last taken	Brought in by Pt.
		Staff Only	

Does someone assist you to manage your medications at home? ☐ No ☐ Yes (who .....)

If you are taking any ***non-prescription medication eg. Complementary therapies****, natural therapies, herbal preparations or vitamins, please specify:* .....)

NB: All complementary medicine should be ceased 10 days prior to admission (unless otherwise instructed by your doctor)

Non-Prescription Medication

Strength	Dose & Frequency	Purpose	Last taken	Brought in by Pt.
			Staff Only	

Has patient brought own stock (including complementary therapies) to hospital? ☐ Yes ☐ No ☐ N/A

If Yes ☐ Sent home ☐ Schedule 8 cupboard ☐ Patient medication drawer ☐ With patient belongings **(SURGICAL CENTRE ONLY)**

DISCHARGE PLANNING (for Day Patients Only)

Who will be taking you home and be with you for 24 hours?

Name ..... Relationship .....

Best contact phone no. ..... Or mobile no. .....

MR26AP3

Family Name	Given Name(s)	Date of Birth	Office Use Only MRN ACN	p4 of 4

Weight and Height Details

What is your weight? .....kg

What is your height? .....cm

Have you lost weight recently without trying?	N	Y ☐ Unsure If **yes**, how much (kg)? ☐1-5 ☐6-10 ☐11 - 15 ☐> 15 ☐Unsure
Have you been eating poorly because of a decreased appetite?	N	Y

Discharge Planning

Do you have problems caring for yourself at home?	N	Y
Do you live alone?	N	Y
Do you care for someone else?	N	Y
Do you receive community services?	N	Y If **yes**, ☐Nurses ☐Home Care ☐Meals on Wheels

Adopted from NSW DOH Final report of the Development of a Risk Screening Tool for Service Needs Following Discharge From Acute Care Project

Valuables (Staff Only) *Whilst all care will be taken SAH does not accept responsibility for valuables or personal belongings.*

Personal property	☐N / A	☐Kept at own risk	☐Ward storage	☐Taken home by .....(sign.)
Valuables	☐N / A	☐Kept at own risk	☐Ward storage	☐Taken home by .....(sign.)

☐ **Cash exceeding $100 placed in hospital safe** **Patient / Carer to sign** .....

Orientation (Staff Only)

	Init		Init		Init		Init
ID band	.....	Call bell	.....	Toilet	.....	Bed controls	.....

Patient History form reviewed by:

PAC staff ☐	Signature.....	Print Name.....	Designation.....	Date /	/20
Surgical Centre staff ☐	Signature.....	Print Name.....	Designation.....	Date /	/20
Ward staff ☐	Signature.....	Print Name.....	Designation.....	Date /	/20
Admitting Nurse ☐	Signature.....	Print Name.....	Designation.....	Date /	/20

SIGNATURE

PATIENT / CARER

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 .....

Date ...../...../.....

Form completed by:

Patient ...../Sign.

Carer ...../Sign.

Admitting Nurse...../Sign.

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