SYDNEY ADVENTIST HOSPITAL

PATIENT HISTORY

To be completed by the patient or carer

Surname _____
Given names _____
DOB _____ Home phone no _____
Address _____

Sydney contact phone no _____
Admission date _____
Admitting doctor _____
Admitting doctor phone no _____

Reason for your admission: .....

.....

.....

Language spoken: English ☐ Other..... Is an interpreter required? Yes ☐ No ☐

Do you consent to the hospital communicating with your General Practitioner if required? Yes ☐ No ☐

If yes, please specify:

GP's full name: .....Phone: .....

Address: .....Fax: .....

PREVIOUS HOSPITALISATION / SURGERY / ILLNESS:

Please tick the Yes or No box regarding your medical history

	Y	N		Y	N		Y	N
Recent cold			Rheumatic fever			Previous blood transfusion		
Bronchitis			Polio, meningitis			Blood clots		
Asthma			Limb paralysis			Back injuries / problems		
Hayfever			Anaemia			Neck injuries / problems		
Emphysema			Jaundice, hepatitis			Infections		
Shortness of breath			Low blood sugar			Do you have any wounds / skin breaks?		
Any other lung problems			Arthritis			Are you pregnant? / weeks		
Elevated cholesterol / triglycerides			Fits / faints / funny turns / epilepsy			Have you had any problems with anaesthetics, eg vomiting		
High blood pressure			Diabetes controlled by			Have you ever smoked? / day		
Chest pain, angina			a) injection			Do you presently smoke? / day		
Heart attack(s)			b) tablet			Do you drink alcohol? / day		
Palpitations			c) diet			Past history of drug dependency		
Do you have a pacemaker?			Thyroid trouble			Do you have Creutzfeldt-Jacob Disease (CJD)?		
Heart murmur			Kidney trouble / dialysis					
Artificial implants/devices			Gout			Have you had:		
Gastric ulcer / reflux			Depression / mental illness			a) Human Pituitary Growth Hormone prior to 1985?		
Stroke			Cancer			b) neurosurgery prior to 1985?		
Varicose veins			Glaucoma					

Please list any previous surgery or illnesses including dates if possible, or any other type of condition that may require further explanation. .....

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What is your: height_____cm weight_____kg

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: .....

SYDNEY ADVENTIST HOSPITAL

PATIENT HISTORY

MR 26A

SYDNEY ADVENTIST HOSPITAL

PATIENT HISTORY

Surname _____

Given names _____

DOB _____

DIETARY REQUIREMENTS

Do you require a special diet? Yes ☐ No ☐ Please specify: .....

.....

.....

ALLERGIES AND SENSITIVITIES

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

Allergy	Sensitivity	Reaction

YOUR CURRENT MEDICATION LIST

Please include all tablets, capsules, puffers, nebulisers, patches, insulin, eye drops.
Please consult your GP or surgeon if you are unsure of any details about your prescribed medications or which medications should be ceased prior to your surgery.
Bring to the hospital all current medications you are taking, in their original packaging.

Prescription drugs

Medication	Strength	Route	Dose	Frequency
Geranin	100mgs	Oral	2 tablets	3 times a day
Asmin	0.4mgs	Inhale	2 puffs	4 times a day

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

Non-prescription medication

Name	Strength	Route	Dose	Frequency

DISCHARGE ARRANGEMENTS

For Day Patients **only:** Have you organised who will take you home? Yes ☐ No ☐

If yes, Name_____Relationship _____Best contact Phone no_____

For inpatients: please note that discharge time is 10am or Mobile 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: .....Date: .....

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