

URN:

Surname:

Given name(s):

Date of birth:

 Sex at birth: ☐ M ☐ F ☐ A

Patient Health History (Adult)

Please complete this form and return to the hospital at least three days prior to the date of your procedure.

Admission date: / / Admitting diagnosis:

Patient details

Title:	Surname:	Given name(s):
Gender:	Sex at birth:	Date of birth: / /

Please indicate if you ever had any of the following conditions and provide relevant details where prompted.

Cardiac	If Yes, provide further details:	
Heart attack	☐ No ☐ Yes	Year:
Angina or chest pain	☐ No ☐ Yes	
Heart failure or heart/valve disease	☐ No ☐ Yes	
Atrial fibrillation, palpitations or other irregular heart beat	☐ No ☐ Yes	Specify:
High blood pressure	☐ No ☐ Yes	
Low blood pressure	☐ No ☐ Yes	
Rheumatic fever	☐ No ☐ Yes	
Cardiac surgery (e.g. pacemaker, internal defibrillator, prosthetic heart valves, grafts, stents, other implants/devices)	☐ No ☐ Yes	Operation(s)/date(s):

Haematology	If Yes, provide further details:	
Have you ever had a blood transfusion?	☐ No ☐ Yes	Describe any reaction:
		Year transfused:
Blood clots in legs (DVT)/lungs (PE)	☐ No ☐ Yes	
Blood disorders (e.g. anaemia)	☐ No ☐ Yes	
Tendency to bleed or bruise easily	☐ No ☐ Yes	

Respiratory and sleep disorders	If Yes, provide further details:	
Asthma, bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), asbestosis, pneumonia or shortness of breath	☐ No ☐ Yes	Do you use: ☐ Nebulisers ☐ Puffers ☐ Home oxygen
Tuberculosis	☐ No ☐ Yes	
Sleep apnoea	☐ No ☐ Yes	Do you use CPAP machine: ☐ Yes ☐ No

Neurology and mental health	If Yes, provide further details:	
Epilepsy or fits	☐ No ☐ Yes	
Anxiety, depression, PTSD or other mental health disorder	☐ No ☐ Yes	
History of self-harm or attempted suicide	☐ No ☐ Yes	
Parkinson's, multiple sclerosis or motor neuron disease	☐ No ☐ Yes	
Stroke (CVA) or TIA	☐ No ☐ Yes	Year: List any impairments:
Dementia, Alzheimer's	☐ No ☐ Yes	
Difficulties with problem solving, attention span or understanding	☐ No ☐ Yes	
Delirium or confusion when ill or in hospital	☐ No ☐ Yes	

Renal	If Yes, provide further details:	
Kidney disease, renal impairment	☐ No ☐ Yes	On dialysis: ☐ Yes ☐ No
Bladder problems (e.g. incontinence, retention)	☐ No ☐ Yes	

Endocrinology	If Yes, provide further details:	
Thyroid problems (e.g. goitre)	☐ No ☐ Yes	
Diabetes	☐ No ☐ Yes	☐ Type 1 ☐ Type 2 ☐ Gestational How is your diabetes managed: ☐ Tablets ☐ Diet ☐ Insulin ☐ Injectables

DO NOT WRITE IN THIS BINDING MARGIN

URN:

Surname:

Given name(s):

Date of birth:

 Sex at birth: ☐ M ☐ F ☐ A

Patient Health History

(Adult)

Musculoskeletal, mobility and falls		If Yes, provide further details:	
Fainting, dizziness or fallen in the last 6 months	☐ No ☐ Yes		
Do you require assistance to mobilise?	☐ No ☐ Yes		
Do you require a mobility aid?	☐ No ☐ Yes	☐ Wheelchair ☐ Walking frame ☐ Stick ☐ Other (specify):	
Arthritis (e.g. osteoarthritis, rheumatoid arthritis)	☐ No ☐ Yes		
Osteoporosis	☐ No ☐ Yes		
Back or neck injury or problems	☐ No ☐ Yes		
Previous back, neck or jaw surgery	☐ No ☐ Yes		

Gastrointestinal		If Yes, provide further details:	
Reflux, heartburn, hiatus hernia, stomach ulcers	☐ No ☐ Yes		
Bowel problems (e.g. Crohn's, IBS, stoma, incontinence)	☐ No ☐ Yes	Specify:	
Liver disease, jaundice, hepatitis	☐ No ☐ Yes		

Skin integrity		If Yes, provide further details:	
Pre-existing wounds or breaks on your skin	☐ No ☐ Yes	Specify wound type and duration:	
Eczema, dermatitis	☐ No ☐ Yes		

Anaesthetic risk and other conditions		If Yes, provide further details:	
Have you had an adverse reaction to anaesthetics?	☐ No ☐ Yes	Type:	
Has a close relative had an adverse reaction to anaesthetics?	☐ No ☐ Yes		
Have you ever had a difficult intubation?	☐ No ☐ Yes		
Do you have dentures, caps, crowns, loose teeth, implants or veneers?	☐ No ☐ Yes		
Do you have difficulty lying flat for periods of time?	☐ No ☐ Yes		
Any other condition(s) we should be aware of?	☐ No ☐ Yes	Specify:	
Have you or a relative ever been diagnosed with malignant hyperthermia?	☐ No ☐ Yes		
Have you had any previous operations or procedures?	☐ No ☐ Yes	Complete procedure and date performed below.	
Procedure	Date performed	Procedure	Date performed
1.	 / /	4.	 / /
2.	 / /	5.	 / /
3.	 / /	6.	 / /

General health and lifestyle		If Yes, provide further details:	
Have you ever smoked?	☐ No ☐ Yes	If <i>current</i> smoker, daily amount: If <i>former</i> smoker, year ceased:	
Do you use recreational drugs?	☐ No ☐ Yes	Have you used recreational drugs in the last 24 hours? ☐ Yes ☐ No	
Do you drink alcohol?	☐ No ☐ Yes	How many drinks containing alcohol do you have on a typical day when you are drinking:	
What is your weight, height and BMI?		Weight (kg): Height (cm): BMI:	
Have you unintentionally lost weight and/or had a decrease in appetite recently?	☐ No ☐ Yes		
Are you pregnant or breastfeeding?	☐ No ☐ Yes	If <i>pregnant</i> , number of weeks:	
Do you live alone?	☐ No ☐ Yes		
Are you a carer for another person?	☐ No ☐ Yes		
Do you require assistance with day to day living?	☐ No ☐ Yes	Specify assistance required:	
Do you have any cultural or religious needs?	☐ No ☐ Yes	Specify need(s):	

DO NOT WRITE IN THIS BINDING MARGIN

(Office use only – Affix identification label here)

URN:

Surname:

Given name(s):

Date of birth:

Sex at birth: ☐ M ☐ F ☐ A

Patient Health History (Adult)

General health and lifestyle (continued)

If Yes, provide further details:

Do you require a special diet?	☐ No	☐ Yes	☐ Diabetic ☐ Coeliac ☐ Vegetarian ☐ Vegan ☐ Lactose free ☐ Dairy free ☐ Kosher ☐ Other (specify):
--------------------------------	-----------------------------	------------------------------	---

Prosthetics and aids

If Yes, provide further details:

Visual aids or visual impairment (e.g. glasses, contact lenses)	☐ No	☐ Yes	
Hearing aids or hearing impairment (e.g. hearing aid, cochlear implant)	☐ No	☐ Yes	
Implanted devices (e.g. metal plates or pins, artificial joint, lap band, intra-ocular lens, pacemaker, stent, defibrillator, heart valve)	☐ No	☐ Yes	

Allergies and adverse reactions (ADR)

If Yes, provide further details:

Do you have any allergies or adverse reactions to medication, tapes, latex, skin solutions or food?	☐ No	☐ Yes	Please enter details below.
Allergy	Reaction		Date/year of reaction

Medications: prescription and complementary

If Yes, provide further details:

Do you take any medications for weight loss (e.g. Ozempic, Wegovy)?	☐ No	☐ Yes	Please enter details below (one per line) or attach/upload a medication list.	
Do you take any medications: prescription, over-the-counter medications, vitamins (e.g. ginkgo, fish/grapeseed oil, St John's Wort)?	☐ No	☐ Yes		
Medication name	Dose	Frequency	Taking for	

If you are taking any blood thinning or arthritis medication (e.g. Warfarin, Plavix, Aspirin) please ensure you have advised your doctor and have received advice on whether you will need to stop any medications prior to admission.

Infection risk and screening

If Yes, provide further details:

Have you tested positive to COVID in the last 4 weeks?	☐ No	☐ Yes	
Do you have a fever and/or respiratory symptoms (e.g. cough, sore throat, runny nose)?	☐ No	☐ Yes	
In the past 4–6 weeks have you or anyone close to you returned from overseas?	☐ No	☐ Yes	
Have you ever been infected with a multi-resistance colonized infection (MRSA/VRE/CRE/CPE)?	☐ No	☐ Yes	
Do you have any blood borne infections (e.g. hepatitis B or C, HIV)?	☐ No	☐ Yes	
Are you currently experiencing any type of infection, or have you been exposed to a person that is suffering an infectious disease in the past 2 weeks (e.g. chickenpox/shingles, measles, conjunctivitis)?	☐ No	☐ Yes	
Have you had vomiting or diarrhoea in the past 48 hours?	☐ No	☐ Yes	
Have you had an overnight stay at an overseas hospital or residential care facility in the past 12 months?	☐ No	☐ Yes	
Complete the additional question below if you are being admitted to a hospital in Western Australia.			
Have you been an inpatient in a hospital, resided in a residential care facility or worked in a hospital or residential care facility outside of Western Australia in the past 12 months?	☐ No	☐ Yes	

DO NOT WRITE IN THIS BINDING MARGIN

URN:

Surname:

Given name(s):

Date of birth:

 Sex at birth: ☐ M ☐ F ☐ A

Patient Health History

(Adult)

Creutzfeldt Jacob Disease (CJD) risk assessment

If Yes, provide further details:

☐ N/A

Complete these questions on CJD if you are having an operation on your eye, brain, spinal cord, pituitary gland or nerve root ganglia.

 Have you had brain or spinal cord surgery that included a dura mater graft prior to 1990? ☐ No ☐ Yes

 Have you taken human pituitary hormone (growth hormone/gonadotrophin) prior to 1986? ☐ No ☐ Yes

 Do you have a family history of CJD? ☐ No ☐ Yes

 Have you received a 'look back or medical in confidence' letter for CJD? ☐ No ☐ Yes

 Have you had an unexplained progressive neurological illness of less than 12 months? ☐ No ☐ Yes

What matters

 Is there anything that matters to you, specifically regarding your hospital stay that we need to know? ☐ No ☐ Yes

If Yes, specify:

 Do you understand your healthcare rights (contact the hospital for further information)? ☐ No ☐ Yes

Legal documentation

If Yes, provide further details:

An Advance Care Directive is a set of written instructions that a person gives that specifies what actions should be taken for their health if they are no longer able to make decisions because of illness or capacity.

 Do you have a current Advance Care Directive? ☐ No ☐ Yes

 Does your Advance Care Directive include a Not for Resuscitation order? ☐ No ☐ Yes

Please attach a copy.

Name (please print):

Contact number:

Enduring Power of Attorney or legally appointed medical treatment decision-maker.

 Do you have an Enduring Power of Attorney or legally appointed medical treatment decision-maker? ☐ No ☐ Yes

Please complete details below and attach a copy.

Name (please print):

Relationship to patient:

Contact number:

Details:

Discharge planning

You must not engage in the following activities for 24 hours following your operation/procedure or as directed by your doctor:

- drive a motor vehicle, ride a bicycle or operate machinery or potentially dangerous appliances;
- make any important decisions or sign legal documents;
- drink alcoholic beverages.

You must arrange and advise the hospital of a responsible adult to drive you home and stay with you overnight. As this is important for your safety after receiving an anaesthetic, failure to do this may result in your procedure being cancelled or postponed.

Details of responsible adult collecting you/the patient:

Escort name (please print):

Relationship to patient:

Contact number:

Patient agreement

I certify that the information provided is true and accurate to the best of my knowledge and I have read and understood the discharge planning requirements as above.

Patient name (please print):

Signature:

Date: / /

Nurse use only

Comments/actions/outcomes:

Name (please print):

Designation:

Signature:

Date: / /

Time (24hr): :

DO NOT WRITE IN THIS BINDING MARGIN

Cura CMR8.0 4/4 v8.00 17/03/2025