

Patient Name: \_\_\_\_\_



# Adult Health Assessment

Queensland Eye Hospital

Surgeon: \_\_\_\_\_



Date of Surgery: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Health Assessment

Do you currently have, or have you ever had any of the following?	Please Document Details		
Heart Attack/ Chest Pain	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Irregular Heart Beat / Arrhythmia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
High Blood Pressure	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Asthma/ Bronchitis/ Chronic Airways Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Home oxygen
Sleep Apnoea	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> CPAP
Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Diet
Stroke/ Blackouts / TIAs / Epilepsy	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Deep Vein Thrombosis / Blood clots	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Gastric Reflux / Heartburn	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Anxiety/ Depression / Dementia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Do you take any blood thinning medication?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Are you / could you be pregnant?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Weeks:
Have you or any blood relative ever had a life threatening reaction to an anaesthetic?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Do you wear glasses or hearing aids?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Glasses <input type="checkbox"/> Hearing Aids
Do you have any prostheses or implants?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Pacemaker <input type="checkbox"/> Joint Replacement
Do you use any aids for mobility?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Wheel Chair <input type="checkbox"/> Walker <input type="checkbox"/> Stick
Have you had any falls recently?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Are you responsible for the care of others?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Do you have any special dietary requirements?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
What is your weight & height?	____ Kg	____ Cm	Nurses use only: BMI:

## Infection Prevention and Control

Are you currently <u>un</u> -well?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Do you currently have any skin infections / breaks / ulcers?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
In the past 2 weeks have you or anyone in close contact to you returned from overseas?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Have you been in contact with anyone who has had any infectious illnesses? e.g. Measles / Chicken pox / Shingles or Cold sores	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Have you had an overnight stay in an overseas hospital in the last 12 months?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Have you ever been infected with a multi-resistant colonized infection (MRSA / VRE)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Do you have any blood borne infections? e.g. Hepatitis B or C, HIV	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

## Creutzfeldt Jacob Disease (CJD) Risk Assessment (Human form of Mad Cow Disease)

Have you had neurosurgery prior to 1989?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Have you taken human pituitary hormone (growth hormone, gonadotrophin) prior to 1985?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Is there a family history of CJD?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Have you received a 'look back' letter for CJD?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	



Patient Name: \_\_\_\_\_

Surgeon: \_\_\_\_\_

Date of Surgery: \_\_\_\_/\_\_\_\_/\_\_\_\_



**IMPORTANT:**

Please **COMPLETE & RETURN** to:  
**P.O. Box 293, Spring Hill, QLD, 4004**

**FAX: (07) 3236 9855**

*Please return at least 1 week prior to the procedure*

**General Practitioner Details** (If requested by surgeon please attach current GP health history report)

General Practitioner: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

**Pre-operative Phone Call**

If you are **unavailable** for a nurse to contact you regarding further health information, who would you like our staff to contact regarding your medical history? Name: \_\_\_\_\_ Phone No. (Day Time) \_\_\_\_\_

**Surgical History**

	Surgery	Year	Surgery	Year
<input type="checkbox"/> None				

**Other Health Issues** (Not already mentioned)

<input type="checkbox"/> None	

**Medications** List all REGULAR Medications including over the counter / complimentary medicines

<input type="checkbox"/> None	

**Allergies / Adverse Reactions** (Please list all known Allergies / Adverse Reactions e.g. Medications, Tapes, Food etc.)

	Drug, Food or Other	Description of Reaction
<input type="checkbox"/> None		

**Post-Operative Instructions**

You must arrange for a responsible adult to drive you home and stay overnight with you following your procedure.

Going home alone and the use of public transport is against the strict policy of Queensland Eye Hospital.

Failure to do this WILL result in your procedure being postponed / cancelled.

The person taking me home is:

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Collection Method: ☐ Car ☐ Taxi ☐ DVA Taxi ☐ Ambulance

My Post-Operative Carer is: ☐ Same as Above Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Patient Declaration** I agree;

- Not to drive a car, motorcycle, ride a bicycle or operate machinery for 24hours after my anaesthetic
- Not to make any important decisions or sign legal documents for 24hours after my anaesthetic
- To be picked up by a responsible adult who will listen to the discharge instructions, and escort me home by private transport.(Bus or Train transport is not permissible)
- To have a responsible adult stay with me overnight.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

