Patient Name: _____

Surgeon: _____

Date of Surgery: _____/ _____/_____

Adult Health Assessment

Queensland Eye Hospital

* E P H A 1 *

Health Assessment

Do you currently have, or have you ever had any of the following?	Please Document Details		
Heart Attack / Chest Pain	☐ No	☐ Yes	
Irregular Heart Beat / Arrhythmia	☐ No	☐ Yes	
High Blood Pressure	☐ No	☐ Yes	
Asthma/ Bronchitis/ Chronic Airways Disease	☐ No	☐ Yes	☐ Home oxygen
Sleep Apnoea	☐ No	☐ Yes	☐ CPAP
Do you currently smoke?	☐ No	☐ Yes	Cigarettes per day _____
Have you ever smoked?	☐ No	☐ Yes	When did you stop? _____
Diabetes	☐ No	☐ Yes	☐ Type 1 ☐ Type 2
Are you taking Insulin or SGLT-2 Inhibitors?	☐ No	☐ Yes	
Stroke/ Blackouts / TIAs / Epilepsy	☐ No	☐ Yes	
Deep Vein Thrombosis / Blood clots	☐ No	☐ Yes	
Do you take any blood thinning medication?	☐ No	☐ Yes	
Gastric Reflux / Heartburn	☐ No	☐ Yes	
Anxiety / Depression / PTSD / Mental Health Disorder	☐ No	☐ Yes	
Dementia or history of Delirium / Confusion when ill or in hospital?	☐ No	☐ Yes	
Are you / could you be pregnant?	☐ No	☐ Yes	Weeks:
Have you or any blood relative ever had a life threatening reaction to an anaesthetic?	☐ No	☐ Yes	
Do you have any vision or hearing impairments?	☐ No	☐ Yes	☐ Glasses ☐ Hearing Aids
Do you have any prostheses or implants?	☐ No	☐ Yes	☐ Pacemaker ☐ Joint Replacement
Do you use any aids for mobility?	☐ No	☐ Yes	☐ Wheel Chair ☐ Walker ☐ Stick
Have you had any falls recently?	☐ No	☐ Yes	
Are you responsible for the care of others?	☐ No	☐ Yes	
Do you have any dietary restrictions?	☐ No	☐ Yes	
What is your weight & height?	____Kg	____Cm	*Nurses use only:* BMI:

Infection Prevention and Control

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

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

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
Is there a family history of CJD?	☐ No	☐ Yes
Have you received a 'look back or medical in confidence' letter for CJD?	☐ No	☐ Yes
Does the patient have an unexplained progressive neurological illness of less than 12 months?	☐ No	☐ 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

Surgical History

	Surgery	Year	Surgery	Year
☐ None				

Other Health Issues (Not already mentioned)

☐ None	

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

☐ None	

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

	Drug, Food or Other	Description of Reaction
☐ None		

Admission Requirements

To meet QEH admission criteria you must:

- Arrange for a responsible adult to drive you home and stay overnight following your procedure. Failure to do this will result in your procedure being postponed or cancelled.
- Not use public transport to travel home as this is against the strict policy of the Queensland Eye Hospital
- Not drive a car, motorcycle, ride a bicycle or operate machinery for 24 hours after an anaesthetic.
- Not make any important decisions or sign legal documents for 24 hours after an anaesthetic.

The person driving you home:

Name: _____ Relationship: _____

Phone: _____ Mobile:_____

Collected by either: ☐ Car ☐ Taxi ☐ DVA Taxi ☐ Ambulance Transfer

Overnight Carer is: ☐ Same as above ☐ Other: _____ Phone: _____

Please return your Patient Details Form and Consent Form as soon as possible to minimise delays with your admission.

Fax: 3236 9855 Email: info@qldeye.com

Nurse use only: This form was completed by a registered nurse at QEH

Nurse Signature:

(Print / Sign / Designation) _____ **Date:** ____ /____ / ____

EPHA2