PERTH EYE HOSPITAL
Our vision is improved vision

42 Ord St, West Perth WA 6005
T: (08) 9216 7900 E: pehtheatres@pertheyehospital.com.au

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Patient Health History

Please complete this form and return by email or in person at least ONE week prior to the date of your procedure, DO NOT POST.

Admission date: ..... / ..... /	Admitting diagnosis:

Patient details

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

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

Cardiac

Heart attack	☐ No	☐ Yes	If Yes, year:
Angina or chest pain	☐ No	☐ Yes	
Heart failure or heart/valve disease	☐ No	☐ Yes	
Atrial fibrillation	☐ No	☐ Yes	
Palpitations or other irregular heartbeat	☐ No	☐ Yes	
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	If Yes, operation(s)/date(s): ....
Family history of heart disease	☐ No	☐ Yes	

Haematology

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

Asthma, bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), asbestosis, pneumonia or shortness of breath	☐ No	☐ Yes	If Yes, do you use: ☐ Nebulisers ☐ Puffers ☐ Home oxygen
Tuberculosis	☐ No	☐ Yes	
Sleep apnoea	☐ No	☐ Yes	If Yes, do you use CPAP machine: ☐ Yes ☐ No

Neurology and mental health

Epilepsy or fits	☐ No	☐ Yes	
Anxiety, depression, PTSD or other mental health disorder	☐ No	☐ Yes	
Parkinson's, multiple sclerosis or motor neuron disease	☐ No	☐ Yes	
Stroke (CVA) or TIA	☐ No	☐ Yes	If 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 impairment/incontinence

Kidney disease, renal impairment	☐ No	☐ Yes	If Yes, on dialysis: ☐ Yes ☐ No
Bladder problems (e.g. incontinence)	☐ No	☐ Yes	

Musculoskeletal and mobility

Fainting, dizziness or fallen in the last 12 months?	☐ No	☐ Yes	
Do you require a mobility aid?	☐ No	☐ Yes	If Yes: ☐ Wheelchair ☐ Walking frame ☐ Stick ☐ Other (specify): .....

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Patient Health History

Musculoskeletal and mobility (continued)

Do you take four or more prescribed medications per day?	☐No	☐Yes	
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

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

Skin integrity

Pre-existing wounds or breaks on your skin?	☐No	☐Yes	If Yes, specify wound type and duration: ....
Eczema/dermatitis	☐No	☐Yes	

Endocrinology

Thyroid problems (e.g. goitre)	☐No	☐Yes	
Diabetes	☐No	☐Yes	If Yes: ☐Type 1 ☐Type 2 ☐Gestational How is it managed: ☐Insulin ☐SGLT-2 inhibitors ☐Diet controlled ☐Other (specify): .....

Anaesthetic risk and other conditions

Have you had an adverse reaction to anaesthetics?	☐No	☐Yes	If 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	
Cancer conditions	☐No	☐Yes	If Yes, type:
Any other condition(s) we should be aware of?	☐No	☐Yes	If Yes, specify: ....
Have you had any previous operations or procedures?	☐No	☐Yes	If Yes, complete procedure and date performed below.

Procedure	Date performed	Procedure	Date performed
1.	../../..	4.	../../..
2.	../../..	5.	../../..
3.	../../..	6.	../../..

General health and lifestyle

Have you ever smoked?	☐No	☐Yes	If current smoker, daily amount: ..... If former smoker, year ceased: .....
Do you use recreational drugs?	☐No	☐Yes	If Yes, specify type and frequency: ....
Do you drink alcohol?	☐No	☐Yes	If Yes, daily amount:
What is your weight, height and BMI?			Weight (kg): ..... Height (cm): ..... BMI: .....
Are you pregnant or breastfeeding?	☐No	☐Yes	If pregnant, number of weeks:
Do you live alone?	☐No	☐Yes	
Are you a carer for another person?	☐No	☐Yes	
Do you currently receive community service?	☐No	☐Yes	If Yes, specify service:

DO NOT WRITE IN THIS BINDING MARGIN

Cura CMR8.0 2/4 v1.00 24/06/2021

FPATHL TH12

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Patient Health History

General health and lifestyle (continued)

Do you require assistance with day to day living?	☐ No	☐ Yes	If Yes, specify assistance required: ....
Do you require a special diet?	☐ No	☐ Yes	If Yes: ☐ Diabetic ☐ Coeliac ☐ Lactose intolerance ☐ Vegetarian ☐ Vegan ☐ Kosher ☐ Other (specify): ..... Please note any foods excluded from your diet (if applicable): ....
Do you have any cultural or religious needs?	☐ No	☐ Yes	If Yes, specify need(s): ....

Prosthetics and aids

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	☐ No	☐ Yes	If Yes: ☐ Artificial joint ☐ Metal plates or pins ☐ Intra-ocular lens ☐ Pacemaker ☐ Defibrillator ☐ Lap band ☐ Stent ☐ Other (specify): .....

Allergies and adverse reactions (ADR)

Do you have any allergies or adverse reactions to medication, tapes, latex, skin solutions or food??	☐ No	☐ Yes	If Yes, please enter details below.

Allergy	Reaction	Date/year of reaction

Medications: pharmaceutical and complementary

Do you take any medications, including all over-the-counter medications and vitamins?	☐ No	☐ Yes	If Yes, please enter details below or attach/upload a medication list.

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

Do you have a fever and/or respiratory symptoms (e.g. cough, sore throat, runny nose)?	☐ No	☐ Yes	
In the past 2 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)?	☐ No	☐ Yes	
Do you have any blood borne infections (e.g. hepatitis B or C, HIV)?	☐ 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)?	☐ No	☐ Yes	
Have you had vomiting or diarrhoea in the past 48 hours?	☐ No	☐ Yes	

Office use only	URN:	Name:	DOB:

Infection risk and screening (continued)

Have you travelled in the last 4–6 weeks?	☐ No	☐ Yes	
Have you had an overnight stay in an overseas hospital 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	

Creutzfeldt Jacob Disease (CJD) risk assessment

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 (see Preadmission Booklet)? ☐ No ☐ Yes

Legal documentation (please attach or bring a copy of any relevant documentation)

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	If Yes, please attach or bring a copy if you would like it included with your medical record, or note below where a copy may be obtained if required.
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	If Yes, please complete details below.
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): ____ : ____