Essendon Day
Procedure Centre

CONFIDENTIAL PATIENT HISTORY

In accordance with the Health Records Act 2001 and the Privacy Act 1988

Please read carefully. If you need an interpreter, please notify our staff, one will be arranged for you.

Declaration

I provide consent for the collection of necessary personal health information and agree to the transfer of relevant health information to other healthcare providers who may be participating in my treatment when requested. It is my understanding that the EDPC staff will make reasonable steps to ensure I am generally aware of the circumstances under which this information is released. I have read and understand the

1. Privacy Statement
2. Australian Charter of Healthcare Rights (ACHCR)- *available in multiple languages. Please ask.*
3. Complaints management process.
4. Child Safety Statement

I understand fees are the responsibility of the patient, parent or guardian.
I understand Medicare does not cover admission to a private or public hospital.
I will inform my doctor of any advanced care directives or treatment limiting orders at my first consultation
I will ring my doctor if there are changes to my medical or medication history prior to surgery. I am aware my doctors are obligated to discuss any unforeseen changes to my treatment plan with myself or my carer.
To the best of my ability the attached medical history is true and correct.

Dr/Mr/Mrs/Ms/Miss/Mst: **SURNAME**: _____**FIRST NAME**:_____

DATE OF BIRTH: (D)_____(M)_____(Y)_____ **MALE/FEMALE**

MARITAL STATUS: Married/Defacto/Widow/Single **COUNTRY OF BIRTH**: _____

Are you of Aboriginal or Torres Strait Island Descent? YES/NO **OCCUPATION**:_____

CONTACT DETAILS: *(HOME)*_____*(WORK)*_____*(MOBILE)*_____

ADDRESS: _____

SUBURB: _____*POST CODE:* _____

POSTAL ADDRESS if different:_____ **EMAIL:**

NEXT OF KIN: _____*(RELATIONSHIP)*:_____PHONE:_____

Do you have Hospital Insurance? YES/NO **Do you have Dental Extras? YES/NO**

NAME OF HEALTH FUND:_____ **MEMBERSHIP NO**:_____

MEDICARE NO: _____ REF NO (number next to your name):_____EXP:_____

Veteran Affairs NO:_____ **TAC/WORK COVER CLAIM NO**: _____

NAME OF DENTIST:_____**NAME OF LOCAL DOCTOR**:_____

PERSON RESPONSIBLE for ACCOUNT *(if different from above)*: Dr/Mr/Mrs/Ms/Miss_____

Email:_____Address:_____PH:_____

Signature *(Patient/Carer)*:

Date: / /

Essendon Day Procedure Centre

Tell us what matters most to you today?

Your past and current medical history is important to us.
We rely on you to provide accurate information. Please complete this form. **BMI-**

1	What is your age?		
2	What is your height?		
3	What is your weight?		
4	Do you have any allergies or alerts? Details:	Yes	No
5	Have you had problems with your lungs, asthma or trouble breathing? Details:	Yes	No
6	Are you taking medication or CPAP for breathing problems?	Yes	No
7	Have you had any problems with your heart or blood pressure? Details:	Yes	No
8	Do you have a pacemaker or artificial heart valve?	Yes	No
9	Do you have diabetes?	Yes	No
10	Have you had any problems with your liver?	Yes	No
11	Do you have kidney disease?	Yes	No
12	Have you had any other serious illnesses?	Yes	No
13	Do you have a history of any bleeding tendencies?	Yes	No
14	Have you had an anaesthetic? What was the procedure?	Yes	No
15	Were there any complications with the surgery or anaesthetic?	Yes	No
16	Are you taking any drugs or tablets? If yes, please specify?	Yes	No
17	Do you have any substance abuse problems with drugs or alcohol? Have you had episodes of delirium, Alzheimer, cognitive impairment, memory loss or mental health issues?	Yes	No
18	Do you have a current infection or contagious disease? e.g. influenza, gastro, cold sore, virus	Yes	No
19	Have you recently travelled overseas? If Yes were you hospitalised for more than 24 hours	Yes	No
20	Have you recently taken Aspirin or other blood thinning medication? *Pradaxa/Clopidogrel/Warfarin/Anti-inflammatory drugs*. Last Dose taken?	Yes	No
21	Do you smoke? How many per day? When did you quit?	Yes	No
22	Do you have any physical disabilities?	Yes	No
23	Have you had two or more accidental falls in the past 12 months?	Yes	No
24	Do you have an Advanced Care Plan and other treatment-limiting orders? Details:	Yes	No
25	Do you have a hearing aid, prosthesis, contact lenses or body piercing?	Yes	No
26	Do you have any loose teeth, caps or crowns?	Yes	No
27	Have you had recent pathology tests? The laboratory name:	Yes	No
29	Have you had recent X-rays? Facility name:	Yes	No
30	Female patients – Are you pregnant? Yes/No Breast feeding?	Yes	No

Name	Dose	Name	Dose

Reviewed by Registered Nurse: Date:

Referred to Anaesthetist: Date:

Pre-operative recommendations: