ESSENDON DAY
PROCEDURE CLINIC

CONFIDENTIAL PATIENT HISTORY

Please read and complete this form carefully. If you need an interpreter call 9326 2666 and we will arrange one for you.

Declaration
In accordance with the Health Records Act 2001 and the Privacy Act 1988 - 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.

- ☐ 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 (unless DVA, Army, TAC or WorkCover).
- ☐ 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.

Title: N/A

Surname: _____ First Name: _____

Sex: Prefer not to disclose Date Of Birth: _____

Marital Status: _____ 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): _____

Suburb: _____ Post Code: _____

Email Address: _____

Next of Kin: _____

Relationship: _____ Phone: _____

Medicare No: _____

Reference No (number next to your name): _____ Expiry: _____

Do you have Hospital Insurance? ○ YES ○ NO

Do you have Dental Extras? ○ YES ○ NO

Name of Health Fund: _____

Membership No: _____ Veteran Affairs No: _____

TAC / Work Cover Claim No: _____

Name of Dentist: _____

Name of Local Doctor: _____

Person Responsible for Account (if different from above): _____

Email: _____ Phone: _____

Address: _____

Suburb: _____ Post Code: _____

Signature: Patient | Carer _____ Date: _____

NEXT PAGE

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Your past and current medical history is important to us. We rely on you to provide accurate information.

What is your age? _____ Height? _____cm Weight? _____kg BMI _____

Do you have any allergies or alerts? ○ Y ○ N

Have you had problems with your lungs, asthma or trouble breathing? ○ Y ○ N

Are you taking medication or CPAP for breathing problems? ○ Y ○ N

Have you had any problems with your heart or blood pressure? ○ Y ○ N

Do you have a pacemaker or artificial heart valve? ○ Y ○ N

Do you have diabetes? ○ Y ○ N

Have you had any problems with your liver? ○ Y ○ N

Do you have kidney disease? ○ Y ○ N

Have you had any other serious illnesses? ○ Y ○ N

Do you have a history of any bleeding tendencies? ○ Y ○ N

Have you had an anaesthetic? ○ Y ○ N

What was the Procedure? _____

_____

_____

Were there any complications with the surgery or anaesthetic? _____

Are you taking any drugs or tablets? ○ Y ○ N

If Yes please note - Name and Dose: _____

_____

_____

Do you have any substance abuse problems with drugs or alcohol? ○ Y ○ N

Have you had episodes of delirium, Alzheimer, cognitive impairment, memory loss or mental health issues? ○ Y ○ N

Do you have a current infection or contagious disease? ○ Y ○ N _____

Have you recently travelled overseas? ○ Y ○ N

If Yes were you hospitalised for more than 24 hrs? ○ Y ○ N

Have you recently taken Aspirin or other blood thinning medication? (Pradaxa / Clopidogrel / Warfarin / Anti-inflammatory drugs). ○ Y ○ N

Last Dose taken? _____

Do you smoke? ○ Y ○ N How many per day? _____ When did you quit? _____

Do you have any physical disabilities? ○ Y ○ N

Details: _____

_____

Have you had two or more accidental falls in the past 12 months? ○ Y ○ N

Do you have an Advanced Care Plan and other treatment-limiting orders? ○ Y ○ N

Details: _____

_____

Do you have a hearing aid, prosthesis, contact lenses or body piercing? ○ Y ○ N

Do you have any loose teeth, caps or crowns? ○ Y ○ N

Have you had recent pathology tests? ○ Y ○ N The laboratory name: _____

Have you had recent X-rays? ○ Y ○ N Facility name: _____

Female patients

Are you pregnant? ○ Y ○ N

Breast feeding? ○ Y ○ N

Is there something you would like to discuss privately with your doctor? ○ Y ○ N

Reviewed by Registered Nurse: _____ Date: _____

Referred to Anaesthetist: _____ Date: _____

Pre-operative recommendations:

_____

PRINT FORM