Northern Health

PRE ADMISSION QUESTIONNAIRE

AFFIX PATIENT IDENTIFICATION LABEL HERE

U.R. NUMBER: _____

SURNAME: _____

GIVEN NAME: _____

DATE OF BIRTH: ____/____/____ SEX: _____

Please complete this questionnaire to the best of your ability. You may ask a relative or friend to assist.
Please return within 7 days of receiving this form.
Return by mail: Theatre Bookings Office. Northern Hospital 185 Cooper Street, Epping 3076
If you need any assistance to fill in this form, or require an interpreter, please call 8405 8521

Please call if you are unwell in the days before surgery e.g.: cold / flu or gastro symptoms or rash.

GENERAL INFORMATION

Preferred Name: _____ Phone: _____ Email: _____

GP's Name: _____ Phone: _____ Email: _____

Do you require an interpreter? ❑ No ❑ Yes → **If YES,** preferred language: _____

Is the interpreter present? ❑ Yes ❑ No

Who is your Medical Treatment Decision Maker? (MTDM or Medical Power of Attorney)

Name: _____

Is this someone you have appointed? ❑ Yes ❑ No

Do you have an advanced care directive (ACD)? ❑ No ❑ Yes → ***If yes, please bring a copy***

Is there any personal or religious reason that you would refuse a blood product or transfusion? ❑ Yes ❑ No

Do you have any special religious or cultural needs? _____

Are you of Aboriginal or Torres Strait Islander origin? ❑ Yes ❑ No

If you are having Day Surgery will someone be able to accompany you home and stay with you overnight?

❑ Yes ❑ No

Who will that person be? Name: _____ Phone Number: _____

ALLERGIES

Do you have allergies to any medications, foods or other products (including latex and chlorhexidine)?

❑ No ❑ Yes → Please list with reactions: _____

_____

Do you have a known anaphylaxis? ❑ Yes ❑ No

When: _____ Which hospital did you attend? _____

Do you have a prescribed adrenaline autoinjector device?

❑ No ❑ Yes → ***If yes, please bring this into hospital with you***

MEDICATIONS - Please list ALL your medications, including puffers, sprays and patches, as well as natural, herbal and over-the-counter medications

Bring all medications with you on coming to hospital

Medication Name	Dose	How Often?	Medication Name	Dose	How Often?

NORTHERN HEALTH

PRE ADMISSION QUESTIONNAIRE

353500

43181
Sep 2019

Northern Health

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PREVIOUS SURGERY & PROCEDURES INCLUDING MENTAL HEALTH ADMISSIONS

Reason / Procedure	Year	Hospital / Clinic	Reason / Procedure	Year	Hospital / Clinic

PREVIOUS ANAESTHETICS

Have you, or a relative, ever had a problem with anaesthetics? ❑ No ❑ Yes **If YES,** when: _____

What happened? _____

Have you ever been told you have a "difficult airway" ❑ Yes ❑ No

Do you have any questions for your anaesthetist, or any other concerns you would like to raise?

_____

HEALTH QUESTIONNAIRE

What is your weight? _____ kg What is your height? _____ cm

Can you lie flat on your back for an hour without any problems with pain, coughing or breathing?	❑ Yes ❑ No
Have you ever smoked (including Shisha and electronic cigarettes)? Do you still smoke? **If NO:** When did you stop? _____ **If YES:** For how long have you smoked? _____ years How much do you smoke per day? _____ per day	❑ Yes ❑ No ❑ Yes ❑ No
Do you drink alcohol? **If YES:** How often? ❑ Daily ❑ Weekly ❑ Monthly ❑ Occasionally If daily, how many drinks per day? _____	❑ Yes ❑ No
Do you use any recreational drugs? If daily, what do you use and how often? _____	❑ Yes ❑ No
Could you be pregnant?	❑ Yes ❑ No
DO YOU HAVE ANY OF THE FOLLOWING: Hearing aid / glasses / contacts / implants? **If YES:** What? _____ Prosthesis (eg. leg / breast) **If YES:** What? _____ Do you have any implanted cardiac devices? (eg. a pacemaker or implanted defibrillator) **If YES:** What type of device: _____ Last checked: ____/____/____ Dentures / plates / loose teeth / crowns / caps? **IF YES:** What? _____	❑ Yes ❑ No
Have you ever had radiotherapy to your head or neck?	❑ Yes ❑ No
Do you have a ❑ PICC ❑ CVC ❑ Port ❑ Shunt ❑ AV Fistula? **If YES:** Location: _____	❑ Yes ❑ No
Do you suffer from motion sickness?	❑ Yes ❑ No
Do you suffer from heartburn or reflux?	❑ Yes ❑ No
Do you suffer from chronic pain? **If YES:** Do you see a pain specialist or other health professional (eg. physiotherapist)? **Details:** _____	❑ Yes ❑ No
Do you snore (loudly enough to be heard through a closed door)?	❑ Yes ❑ No
Do you often feel tired, fatigued or sleepy during the day?	❑ Yes ❑ No
Has anyone observed you stopping breathing, choking or gasping in your sleep?	❑ Yes ❑ No
Have you ever been told you have sleep apnoea? **If YES:** Do you use a CPAP machine? ***If you do, please bring this into hospital with you.***	❑ Yes ❑ No ❑ Yes ❑ No
Do you have a history of multi resistant organism? (VRE / ESBL / MRSA (golden staph) / CPE)	❑ Yes ❑ No
Have you been admitted to a hospital in Australia for > 24 hours in the past 12 months?	❑ Yes ❑ No

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Have you been admitted to an overseas hospital / aged care facility or attended an overseas renal dialysis / oncology unit or had an endoscopy overseas in the last 12 months?	❑ Yes ❑ No
Have you had or been vaccinated against? Measles: ❑ Yes ❑ No Chicken pox: ❑ Yes ❑ No	
Do you have a family history of Creutzfelt Jacob Disease (CJD)?	❑ Yes ❑ No
Do you have a progressive neurological disorder of less than 12 months?	❑ Yes ❑ No

CAN YOU:

Take care of yourself (feeding, dressing and bathing)?	❑ Yes ❑ No
Walk around indoors, such as around your house?	❑ Yes ❑ No
Walk a block or two on level ground?	❑ Yes ❑ No
Climb a flight of stairs or walk up a hill without stopping?	❑ Yes ❑ No
Run a short distance?	❑ Yes ❑ No
Do light work around the house (eg. vacuuming, sweeping floors, carrying groceries)?	❑ Yes ❑ No
Do moderate intensity work around the house (eg. scrubbing floors, lifting or moving heavy furniture)?	❑ Yes ❑ No
Do yard work (eg. raking leaves, weeding and pushing a lawnmower)?	❑ Yes ❑ No
Have sexual relations?	❑ Yes ❑ No
Participate in moderate intensity recreational activities?	❑ Yes ❑ No
Participate in strenuous sporting activities?	❑ Yes ❑ No

DO YOU HAVE OR HAVE YOU EVER HAD:

CANCER? **If YES:** What type? _____	❑ Yes ❑ No
High blood pressure / hypertension?	❑ Yes ❑ No
Chest pain / angina? **If YES:** What causes your chest pain / angina? _____ How often do you get it? _____	❑ Yes ❑ No
A heart attack? **If YES:** When? _____ Which hospital treated you? _____	❑ Yes ❑ No
Heart surgery or a cardiac stent? **If YES:** When? _____ Which hospital? _____	❑ Yes ❑ No

An irregular heartbeat / palpitations or arrhythmia?	❑ Yes ❑ No	Liver disease?	❑ Yes ❑ No
Heart failure?	❑ Yes ❑ No	Kidney disease?	❑ Yes ❑ No
Shortness of breath when lying flat?	❑ Yes ❑ No	Dialysis?	❑ Yes ❑ No
Disease of the heart valves?	❑ Yes ❑ No	Arthritis?	❑ Yes ❑ No
Pulmonary hypertension?	❑ Yes ❑ No	Limited neck movement?	❑ Yes ❑ No
Asthma?	❑ Yes ❑ No	Depression / anxiety?	❑ Yes ❑ No
Other lung disease?	❑ Yes ❑ No	A mental health condition?	❑ Yes ❑ No
Congenital heart disease ("Childhood heart disease")?	❑ Yes ❑ No	Phobias (including needle phobia)?	❑ Yes ❑ No
Anaemia ("Low blood count")?	❑ Yes ❑ No	Epilepsy / fits or seizures?	❑ Yes ❑ No
Low iron?	❑ Yes ❑ No	A stroke?	❑ Yes ❑ No
A bleeding disorder?	❑ Yes ❑ No	Parkinson's disease?	❑ Yes ❑ No
Blood clots?	❑ Yes ❑ No	Thyroid disease?	❑ Yes ❑ No

Blood transfusions? ❑ No ❑ Yes → ***Have you ever had a reaction to a blood product or transfusion?*** ❑ Yes ❑ No
If YES, details: _____

Have you been on steroid medication within the last 3 months?	❑ Yes ❑ No
Diabetes? **If YES:** Have you had a blood test for diabetes (HbA1c) within the last 3 months? **If YES:** What was it? _____ mmol / Litre	❑ Yes ❑ No ❑ Yes ❑ No
Other health conditions? **If YES, details:** _____	❑ Yes ❑ No

Is there any other information that we need to know that would help us care for you?

_____

_____

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ABOUT YOU:

Do you have a carer? **If YES,** who: _____ **If YES,** will your carer be able to stay with you in the Day Procedure Unit during your stay?	❑ Yes ❑ No ❑ Yes ❑ No
Are you a carer for someone else?	❑ Yes ❑ No
Do you have a case manager? **If YES,** name: _____	❑ Yes ❑ No
Do you require any special diet or fluids? **If YES, details:** _____	❑ Yes ❑ No
Are you on a fluid restriction? **If YES, details:** _____	❑ Yes ❑ No
Do you have any trouble swallowing? **If YES, details:** _____	❑ Yes ❑ No
Do you have any current wounds? **If YES, details:** _____	❑ Yes ❑ No
Do you have a current bedsore / pressure injury? **If YES, details:** _____	❑ Yes ❑ No
Have you ever had a bedsore?	❑ Yes ❑ No
Are you confined to bed or chair for most of the day, or immobile?	❑ Yes ❑ No
Have you had a fall in the last 12 months?	❑ Yes ❑ No
Do you have any problems with your balance / movement or dizziness that affects your walking?	❑ Yes ❑ No
Are you incontinent with your bladder?	❑ Yes ❑ No
Are you incontinent with your bowel?	❑ Yes ❑ No
Do you have a catheter?	❑ Yes ❑ No
Do you have a stoma? **If YES, details:** _____	❑ Yes ❑ No
Do you have a known cognitive impairment, such as Alzheimer's disease or dementia?	❑ Yes ❑ No
Does your family have any information on strategies or triggers that may assist us to communicate with you? _____	

IF YOU ARE 65 YEARS OR OLDER:

How often did you feel tired in the past 4 weeks? ❑ All the time ❑ Some of the time ❑ None of the time

By yourself and not using aids, do you have difficulty walking up 10 steps without resting?	❑ Yes ❑ No
By yourself and not using aids, do you have any difficulty walking several hundred metres?	❑ Yes ❑ No
Have you lost more than 5% of your weight without trying, over the past year?	❑ Yes ❑ No
Have you previously had episodes of confusion or delirium?	❑ Yes ❑ No

Do you require a medical certificate? ❑ Yes ❑ No

Please sign that the above information is correct.

Name: _____ Signature: _____ Date: _____/_____/_____

If a relative / friend filled out this form for you can they please sign that the above information is correct.

Name: _____ Signature: _____ Date: _____/_____/_____

Office Use Only

Confirmation of Information:

Name: _____ Signature: _____ Date: _____/_____/_____

Confirmation of Information:

Name: _____ Signature: _____ Date: _____/_____/_____

Planned Surgery: _____ Primary Care BP: _____ / _____ Estimated ASA: _____

BMI: _____ HbA1c: _____ mmol / mol STOP – Bang: _____

DASI: _____ FRAIL Score: _____ Planned Day Surgery? ❑ Yes ❑ No

Suitable for BH? ❑ Yes ❑ No PAC: ❑ Phone PAC ❑ Surgical PAC ❑ Anaesthetic PAC

Reviewed by: Name: _____ Signature: _____ Date: _____/_____/_____

Discussed with: Name: _____ Signature: _____ Date: _____/_____/_____

DASI: The value of the Duke Activity Status Index (DASI) in predicting ischaemia in myocardial perfusion scintigraphy - a prospective study. George MJ1, Kasbekar SA, Bhagawati D, Hall M, Buscombe JR.

STOP – BANG: A Tool to Screen Patients for Obstructive Sleep Apnea. Frances Chung, F.R.C.P.C.,* Balaji Yegneswaran, M.B.B.S.,† Pu Liao, M.D.,‡ Sharon A. Chung, Ph.D.,§ Santhira Vairavanathan, M.B.B.S.,_ Sazzadul Islam, M.Sc.,_ Ali Khajehdehi, M.D.,† Colin M. Shapiro, F.R.C.P.C.# Anaesthesiology 2008; 108:812–21 Copyright © 2008, the American Society of Anesthesiologists, Inc. Lippincott Williams & Wilkins, Inc.

FRAIL Scale: Morley, J. E., Malmstrom, T. K., & Miller, D. K. (2012). A simple frailty questionnaire (FRAIL) predicts outcomes in middle aged African Americans. The journal of nutrition, health & aging, 16(7), 601-608.