Health Assessment Form

HONEYSUCKLE Day Hospital
Premium care, Optimum results

OFFICE USE ONLY	
Date of Admission:	Surgeon:
Procedure:	

PATIENT DETAILS		
Title:	Given Name(s):	Surname:

GENERAL PRACTITIONER DETAILS	
Name:	Practice Name:
Address:	Telephone:
Do you consent to the hospital communicating with your General Practitioner if required?	Yes ☐ No ☐

PATIENT MEDICAL HISTORY (to be completed by patient or GP)				
Physical	Height: cm/feet		Weight: kg/stones	
Previous Surgery	List details of previous surgery and dates:			
Cardiac	Hypertension / High Blood Pressure	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
	High Cholesterol	☐ Yes ☐ No	Blood Clot on Lungs / Legs (DVT)	☐ Yes ☐ No
	Heart attack / AMI Date	☐ Yes ☐ No	Anaemia	☐ Yes ☐ No
	Diabetes: Type 1 Type 2 IDDM Insulin Dependant NIDDM Diet controlled, Inslin, Tablet	☐ Yes ☐ No	Chest Pain / Angina	☐ Yes ☐ No
			Do you have a Joint or Heart Valve Replacement, Angoplasty / Stent, Pacemaker / Defibrillator or Eye Implant?	☐ Yes ☐ No
Respiratory	Chronic Obstructive Airway Disease	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
	Asthma / Bronchitis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
	Pneumonia	☐ Yes ☐ No	Have you recently had Cough, Cold or Sore Throat	☐ Yes ☐ No
Vascular	Peripheral Vascular Disease	☐ Yes ☐ No	Pressure Ulcer Where: ______________________	☐ Yes ☐ No
GIT / GUT	Indigestion or Reflux	☐ Yes ☐ No	Hepatits or Jaundice	☐ Yes ☐ No
	Kidney Disease	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Neurological	Stroke	☐ Yes ☐ No	Back or Neck Problems	☐ Yes ☐ No
	Epilepsy or Other Fits	☐ Yes ☐ No	Stress Related Conditions	☐ Yes ☐ No
	Fainting / Dizziness	☐ Yes ☐ No	Sleep Disorders	☐ Yes ☐ No
Other	Cancer Type: ____________________________ Site(s): __________________________	☐ Yes ☐ No	Have you ever had any reason to believe that you are in a high-risk group for Hepatits or HIV (AIDS Virus)?	☐ Yes ☐ No
	Arthritis	☐ Yes ☐ No	Any other Medical Disease or Illness?	☐ Yes ☐ No
	Eczema / Dermatitis	☐ Yes ☐ No		

Do not write in this space.

V5.1 15th January 2024

MR 1.2

Health Assessment Form V5.1 15th January 2024 MR 1.2

Do not write in this space.

PATIENT MEDICAL HISTORY (Continued)

Category	Question	Response	Question	Response
Other	Have you or a member of your family ever had any problems with General Anaesthetics? Details:	☐ Yes ☐ No	Do you tend to bleed or bruise eaily? Details:	☐ Yes ☐ No
	Hay Fever	☐ Yes ☐ No	Females: Are you Pregnant?	☐ Yes ☐ No
	Have you ever had a blood transfusion? If Yes, have you ever had a reaction?	☐ Yes ☐ No ☐ Yes ☐ No	Do you wear a Dental Appliance, Cap, Plate, Crown or Bridge?	☐ Yes ☐ No
Lifestyle	Do you drink Alcohol? Daily Intake: ______________________ Do you smoke? Have you ever smoked? How many per week? _______________	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	Do you use, or have you used, any recreational drugs in the past year? Details:	☐ Yes ☐ No
Medication	Have you had any aspirin in the last week? How many and when:	☐ Yes ☐ No	Do you take any unprescribed drugs or other substances? (i.e Over-the-Counter medications, fish oils, supplements, garlic capsules) Details:	☐ Yes ☐ No
	Have you had any cortisone / steroids in the past 6 month? If yes, state whether tablets, injection or cream: ___________________________	☐ Yes ☐ No	Are you currently on Warfarin or Anti-Platelet drugs?	☐ Yes ☐ No
Current Medication (Attach Sheet if Required)	Drug:		Dose:	Frequency:
ACD	Do you have an Advanced Care Directive in place?			☐ Yes ☐ No
Infections	Have you had HIV, Hepatitis B or C?	☐ Yes ☐ No	When:	
	Have you had Tuberculosis, MRSA, VRE or CRE?	☐ Yes ☐ No	When?	
Allergies	Do you have any allergies to tapes, lotions, food (i.e Kiwi Fruit, Banana), Latex or Rubber?	☐ Yes ☐ No	Details:	
	Do you have any allergies to drugs?	☐ Yes ☐ No	Details:	
	Do you have any other allergies?	☐ Yes ☐ No	Details:	
CJD Risk Screening	Do you have a family history of 2 or more first-degree relatives with Creutzfeldt-Jakob Disease or other undiagnosed neurological illness?	☐ Yes ☐ No	Did you undergo brain surgery (neurosurgery) before 1990?	☐ Yes ☐ No
	To your knowledge, did you receive pituitary hormone injections before 1986?	☐ Yes ☐ No	If yes, what type of operation was performed and who was the surgeon/hospital?	
SARS	Have you been in contact with a person known to have SARS in the last 10 days?	☐ Yes ☐ No	Have you travelled from overseas in the last 10 days?	☐ Yes ☐ No

PATIENT DECLARATION

I have carefully read all the above and I certify that the information I have given is correct and true to the best of my ability:

PRINT NAME:	SIGNATURE:	DATE:
		/ /