SYDNEY DAY HOSPITAL

Please complete the following and bring it with you on the day of surgery.

Surname: _____ Surgeon:_____

First Name: _____ Operation Date: ___/___/___ Time: _____

Date of Birth: ___/___/___ Patient Tel/Mobile:_____ Approx. Weight: _____

Please list below all medications you are currently taking, including vitamins and alternative medicines

CURRENT MEDICATIONS	DOSE	FREQUENCY	TIME(S) THAT YOU TAKE IT		
			Morning	Noon	Evening

Do you smoke? NO YES Amount per day:_____

Do you drink Alcohol? NO YES Amount per day:_____

Females are you pregnant? NO YES

DO YOU HAVE ANY ALLERGIES e.g. Latex, Medications, Food? YES NO

If yes please list: _____

_____

Please list previous operations and approximate dates:_____

_____

_____

Have you had any problems with a local or general anaesthetic previously? YES NO

If yes, what did you experience or what was the problem?_____

_____

Do you have a family history of anaesthetic problems? YES NO

If yes, please give details:_____

_____

Do you have any Healthcare needs that need to be addressed? YES NO

If yes, please give details: _____

_____

SYDNEY DAY HOSPITAL

Do you have an Advanced Care Plan? NO YES

If you circled YES for the staff to support you fully please document clearly below what your limit of

Advanced Care is: _____

_____

Questions relating to Creutzfeldt Jakob Disease	YES	NO
Do you have a family history of two or more first degree relatives with Creutzfeldt Jakob Disease or other unspecified neurological disorder? *If you have a family history of CJD you would know and have undergone genetic studies identifying if you carry the Gene that pre-disposes you to CJD*		
Have you received Human Pituitary Hormone prior to 1986? (Growth, Gonadotrophin – for infertility) *A national register of those patients who have received pituitary hormone exists. Therefore all of these patients know and have received follow up counselling.*		
Have you had brain surgery? If so please provide further details.		

Questions relating to Candida auris	YES	NO
Have you been hospitalised overseas since 2017?		
Have you or any family members ever been confirmed as a carrier of Candida auris?		

Please indicate which conditions affect or have ever affected you:

Condition	YES	NO	Staff Use Only
Heart Trouble/Heart Attack/Stroke			
Pacemaker			
Chest Pain			
High Blood Pressure			
Reflux or Indigestion			
Asthma/Breathlessness/Persistent Cough/lung disease			
Liver Disease/Hepatitis			
Epilepsy/Fits/Blackout/Dizzy Spells			
Diabetes			
Anaemia			
Blood Transfusion			
Bleeding Tendencies			
Back or Hip Problems			
Have you taken Aspirin/warfarin in the last week			
Steroid/Cortisone in Last 6 months			
Are you in a high risk group for Hep B, C,HIV			
Do you have any pressure sores/ulcers?			
Do you use any mobility aides?			
Are you at risk of having a fall?			
Do you have any cognitive impairment?			
Do you have any mental Health issues?			

I have completed this questionnaire to the best of my knowledge and understand that failure to make a full disclosure may place me at undue medical risk

Signed: _____ Date:_____