



Health Assessment

HOSPITAL ADMINISTRATION SECTION ONLY		
Family name:	First names:	
UR:	Date of birth:	Gender:
Affix patient label here:		

Patient Medical & Surgical History

SURGEON:

DATE:

PROCEDURE:

Physical	DOB:	Age:	
	Height: (cm)	Weight: (kg)	
Cardiac	High blood pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	
	High cholesterol	<input type="checkbox"/> No <input type="checkbox"/> Yes	
	Anaemia	<input type="checkbox"/> No <input type="checkbox"/> Yes	
	Chest pain / Angina	<input type="checkbox"/> No <input type="checkbox"/> Yes	
	Heart attack / AMI	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date:
	Blood clot - lungs (PE) / legs (DVT)	<input type="checkbox"/> No <input type="checkbox"/> Yes	
	Rheumatic fever	<input type="checkbox"/> No <input type="checkbox"/> Yes	
	Smoking	<input type="checkbox"/> No <input type="checkbox"/> Yes	Amount Daily:
Endocrine	Diabetes:	<input type="checkbox"/> No <input type="checkbox"/> Yes	
		If yes: <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2	<input type="checkbox"/> IDDM Insulin Dependent <input type="checkbox"/> NIDDM Diet / Insulin / Tablet

Respiratory	Chronic Obstructive Pulmonary Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
	Asthma	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
	Bronchitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
	Hay fever	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
	Pneumonia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date:
	Shortness of breath	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
	Recent infection (within 2 months)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
Vascular	Peripheral Vascular Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
	Varicose veins	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
	Poor circulation – hands / feet	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
	Pressure Ulcer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Location:
	Venous Ulcer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Location:
GI	Indigestion / reflux	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
	Bowel disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
	Incontinence issues	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Bowel <input type="checkbox"/> Bladder
	Kidney disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
	Liver disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Neurological	Cognitive impairment	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
	Dementia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
	Down Syndrome	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
	Cerebral Palsy	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
	Stroke	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
	TIA – Transient Ischaemic Attack	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
	Epilepsy / seizure	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
	Sleep disorders	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

Neurological Continued	Fainting / dizziness (Within the last 12 months)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
	Fall history (Within the last 12 months)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
	Neck or spine issue	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
Mental	Do you have a diagnosed mental health condition?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
	Have you had thoughts of self-harm or suicide? (Within the last 12 months)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
	Do you have a history of aggression? (Within the last 12 months)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
	Are you under the care of a doctor?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
	Do you require additional support during your admission?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
Dietary Needs	Specific nutritional requirements: (Including texture modified diets & fluids)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
	Enteral feeding	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
	Coeliac / gluten intolerant	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
	Lactose intolerant	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
	Vegetarian	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
	Vegan	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
	Halal	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
	Kosher	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Other	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:	

Surgical History	Previous surgery	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details (List all surgeries):
	Anaesthetic issues – include family history	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
	History of Malignant Hyperthermia – self or direct family member?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
	History of known difficult airway or intubation?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
Allergies	Drug allergies	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
	Food allergies	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
	Previous anaphylaxis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
	Other	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
Additional History	Pregnant <input type="checkbox"/> N/A	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
	Eczema / dermatitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
	Arthritis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
	Mobility aids	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
	Vision impaired / glasses	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
	Hearing impaired / aids	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
	Caps / crowns / dentures	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
	Fragile skin	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
	Bleed / bruise easily	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
	Blood transfusions	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
	Transfusion reactions	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
	Alcohol intake	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Amount & Frequency:
	Recreational drugs	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Type & Last Dose:

Current Medication	Blood thinners	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
	Blood thinners ceased <input type="checkbox"/> N/A	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date:
	Steroids / cortisone	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
	Steroids / cortisone ceased / last dose	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date:
	Cytotoxic medication	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
	Cytotoxic medication ceased / Last dose	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date:
	Prescribed medication list:			
	Non-prescribed medication list:			
Infectious Diseases	Overseas travel – previous 10 days	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
	Hospital admission – previous 2 months	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
	COVID-19 previous positive	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date:
	Current COVID-19 close contact	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
	If previous positive COVID-19 describe severity of symptoms	Details:		
	MRSA / Golden Staph	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
	VRE	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
	HIV / AIDS / Hepatitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
Creutzfeldt – Jakob Disease	Pituitary Hormone Injections – before 1986	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
	Family history	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:

I CONSENT TO CANOSSA PRIVATE HOSPITAL STAFF PROVIDING THE FOLLOWING CARE (TICK TO INDICATE CONSENT):

- Medications as ordered by my medical practitioner
- Physical care including assistance with activities of daily living and mobility, other care, and assistance reasonably incidental to the above
- Physical therapies

I UNDERSTAND THAT I AM RESPONSIBLE FOR THE FOLLOWING:

- Providing accurate information regarding my current private health insurance
- Complete payment of all accounts associated with this admission
- In the event of an emergency I understand that I may need to be transferred to another medical facility for ongoing treatment as medical staff are not on site 24 hours/day.
- I hereby release the hospital and hospital staff from all liability for any adverse results arising if I remove myself/ this patient from the hospital at my own insistence and against the advice of the hospital staff and medical practitioner.
- If applicable, I agree to provide a copy of my Advanced Health Directive to Canossa Private Hospital. In the event I do not provide this document I accept the hospital may not have knowledge of my health decisions.

USE OF MY PERSONAL INFORMATION

- In some cases the Australian Privacy Principles prohibit the use of personal information that Canossa Private Hospital collects and holds, if you do not consent to the use of such information. You are under no obligation to provide consent to the use of your personal information.
If you provide consent, the information will be used in a format where your identity will be clear in any material generated. If you do not consent, we will respect your wishes and will inform you if this affects our ability to provide care and services to you. Our privacy policy is available on our website canossahospital.org.au and is available to view at our facility.

I CONSENT TO THE FOLLOWING:

- The sharing of relevant medical and personal information to other medical practitioners or institutions who may treat me in the future
- Notify next of kin of treatment outcomes
- To obtain consent to necessary treatment when I am not able to provide such consent
- To inform visitors of, and forward telephone enquiries and calls to my location within the facility
- Medical, nursing, allied health and students accessing my health records for the purpose of education and training
- Canossa Private Hospital to access to my Health Fund of which I am a member, if requested by the Health Fund to do so
- Canossa Private Hospital communicating promotional material and special events to me

I (insert name)

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have read the above and certify that the information I have provided is true and correct at the time of completing the documents. I consent to all statement unless I have documented NO beside the applicable statement.

NAME:

SIGNATURE:

DATE:

