

DAY SURGERY PRE ADMISSION QUESTIONNAIRE

180 Fullarton Road, Dulwich SA 5065
Telephone: (08) 8333 8111 Fax: (08) 8333 8188

Dear Patient,

We depend on you to provide accurate health screening information. To help us, you are requested to complete this questionnaire on the day of admission.

PATIENT SURNAME: **Mr** **Miss** **Mrs** **Ms** OTHER NAMES:

ADDRESS: SUBURB:

STATE: POSTCODE: TELEPHONE Home Bus.

SEX: M F DATE OF BIRTH:.....

QUESTIONNAIRE

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| <p>1. Have you had any anaesthetics in the past? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>2. Have you had any problems with any anaesthetics? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>3. Have you any blood relatives who have had anaesthetics problems? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>4. Are you taking any drugs or tablets? If so, please specify? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>5. Have you had any Aspirin in the past 2 weeks? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>6. Have you any allergies? State allergies: YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>7. Have you had any problems with your heart? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>8. Have you had any problems with your blood pressure? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>9. Do you have heartburn or reflux? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>10. Have you had trouble breathing or taken medication for a breathing problem? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>11. Do you suffer from hayfever? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>12. Do you smoke? How many/day? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>13. Do you have caps, crowns, dentures or loose teeth? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>14. Do you have any neck or jaw stiffness? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>15. Have you had any psychiatric treatment? YES <input type="checkbox"/> NO <input type="checkbox"/></p> | <p>16. Have you had jaundice, hepatitis or liver disease? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>17. Do you drink alcohol? How many glasses /day? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>18. Have you had a history of any bleeding tendencies? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>19. Do you have any kidney disease? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>20. Do you have diabetes? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>21. Have you had any other serious illnesses? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>22. Do you have any physical disabilities? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>23. Could you be pregnant? If yes, how many weeks? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>24. Do you suffer from fits, seizures or blackouts? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>25. Do you have any back problems? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>26. Have you received a dura mater graft (between 1972 & 1989)? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>27. Do you or any family members have a history of Creutzfeldt - Jakob Disease (CJD) or related disease? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>28. Have you received human pituitary hormone (growth, gonadotrophin) prior to 1985? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>29. Has there been any recent progressive dementia (physical or mental), the cause of which has not been diagnosed? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>PLEASE ADVISE THE INFECTION CONTROL COORDINATOR IF QUESTIONS 26 TO 29 HAVE A 'YES' RESPONSE.</p> |
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Thank you for your help. We look forward to caring for you.

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| <p>NURSING ASSESSMENT (For Nursing Use Only)</p> | <p>PRE-OPERATIVE CHECK LIST</p> <p>ID band checked? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Consent? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Rings taped/Jewellery Removed YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Make-up and Nail Varnish Removed YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>X-Rays? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Sick certificate required? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <hr/> <p>Signature of RN/EN:</p> <p>Print Name:</p> |
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