bayside endoscopy DAY HOSPITAL

441 South Road
Bentleigh VIC 3204
Tel: (03) 9553 2422
Fax: (03) 9553 2466

Web: www.melbendoscopy.com.au
Email: bayside@melbendoscopy.com.au

Patient Label

MEDICAL PRE-ADMISSION FORM

Please answer all questions

Please return this form 7 days prior to your admission date, either by email, post or fax.

Patient Name: .....

Date of Procedure: ..... Time of Admission: ..... Procedure: .....

Height: ..... Weight: ..... BMI (if known) .....

Medical Conditions	Yes	No	Further Information
Heart problems e.g. heart attack, stents, chest pain, angina, palpitations, irregular heartbeat, etc.			Specify: Date:
Stroke/TIA			Any impairment/deficit: Date:
Blood pressure			☐ High ☐ Low
Pacemaker			☐ Fixed ☐ Defibrilating Date inserted: Year .....
Cancer			☐ Chemotherapy ☐ Radiotherapy
Females: Are you pregnant or breastfeeding Blood clots: Legs/Lungs			If you are pregnant or possibly pregnant please confirm with specialist prior to admission Is this clot current? ☐ Yes ☐ No
Bruising or bleeding tendency			Specify:
Respiratory issues e.g. asthma, bronchitis, pneumonia, shortness of breath etc.			Specify Issue: Is this condition worsening? ☐ Yes ☐ No ☐ Nebulisers ☐ Puffers ☐ Home Oxygen
Sleep apnoea			Do you use a CPAP Machine? ☐ Yes ☐ No
Depression or mental health issues			Do you require a carer? ☐ Yes ☐ No
Rheumatic Fever			
Kidney Disease			
Liver Disease			
Thyroid problems			Specify:
Anaemia			
Diabetes			☐ Type 1 ☐ Type 2 ☐ Insulin ☐ Tablets ☐ Diet
Epilepsy/Fits/Convulsions			Specify:
Heartburn/Reflux/Gastrointestinal disorders			
Hearing impairment			☐ Hearing Aid ☐ Left ☐ Right ☐ Bilateral Did you bring them with you? ☐ Yes ☐ No
Do you wear glasses?			Did you bring them with you? ☐ Yes ☐ No
Do you have any loose/chipped teeth, dentures,			Specify: ☐ Yes ☐ No
Other Implants/Prosthetic Devices, eg. stents, joint replacements, pins/plates			Specify:
Do you have an advanced care directive or treatment limiting order?			If yes, please bring a copy on admission
ALLERGIES AND ADVERSE REACTIONS			**FURTHER INFORMATION**
Allergy/Sensitivity (including drugs, food, latex)			Specify:
ANAESTHETIC HISTORY			**FURTHER INFORMATION**
Have you ever had any complications from an anaesthetic in the past?			Specify:
Have you ever been tested or diagnosed with malignant hyperthermia?	**Yes**	**No**	Specify:

Full Name:

SURGICAL HISTORY

Please list previous operations/procedures and dates

DATE	DESCRIPTION
/ /	
/ /	
/ /	
/ /	

CURRENT MEDICATIONS

List any medications, vitamins, inhalers, complementary, over the counter medications and supplements you are taking

Drug	Dose	Frequency	Drug	Dose	Frequency

Do you take any blood thinning medication? E.g. aspirin, Plavix, Warfarin	Yes	No	Specify: Have you been asked to cease this prior to admission ☐ Yes ☐ No

INFECTION CONTROL	YES	NO	FURTHER INFORMATION
Have you currently or recently been suffering with a cold, cough, chest infection, temperature.			Specify:
Have you or a family member been exposed to, or had a communicable disease in the last 2 weeks, eg. chicken pox, pneumonia, measles, shingles, scabies, whooping cough, TB?			Specify:
Do you have HIV, Hepatitis A/B/C, MRSA, VRE, CRE, Clostridium difficile, or other infectious diseases?			Specify:
Have you been overseas in the last year? Where and when?			Specify:
Have you been admitted to hospital in the last year?			Specify:

LIFESTYLE	YES	NO	FURTHER INFORMATION
Do you smoke:			Cigarettes per day:
Do you drink alcohol?			Daily alcohol intake:
Do you take recreational drugs?			Specify:

FALLS ASSESSMENT	YES	NO	FURTHER INFORMATION
Have you had a fall in the last 6 months?			Number of falls ☐ 1 ☐ 2 ☐ 3 or more
Do you use a walking aid?			Specify:
Do you need help walking, moving, dressing or undressing?			
Are you visually impaired?			
Do you have a history of migraines, fainting, dizziness or balance problems?			Specify:

SKIN ASSESSMENT	YES	NO	FURTHER INFORMATION
Do you have compromised skin integrity eg. cuts, burns ulcers, wounds, bruises, skin disorders, etc.			Specify:

The answers I have given to all the questions are true to the best of my knowledge and I have not withheld any information

Patient Name: .....

Patient/Guardian Signature: .....

Reviewed by Name: .....

Signature: .....

Designation:.....Date:.....

If there is any section within the admission/medical history forms which require clarification or you have any other information which will enable us to individualise your care, please do not hesitate to contact the centre any time prior to you admission on **9553 2422**.