Seymour Health
1 Bretonneux Street,Seymour, Vic, 3660
☎ (03) 5793 6100

PRE-OPERATIVE ASSESSMENT

(Please place identification label here)

UR No: ______________________

Name: ______________________

Address: ______________________

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Date of Birth: ______/______/______

All patients are requested to complete this pre-operative assessment questionnaire and return to Seymour Health at least 10 working days prior to operation/procedure. Failure to do so may result in rescheduling or cancelling of your appointment.

Surgeon: **Proposed procedure:** **Date:**

List previous operations including approximate dates and places:

How tall are you? __________cm How much do you weigh? BMI________

PLEASE ANSWER ALL QUESTIONS

Do you have any ALLERGIES / SENSITIVITIES to: ☐ No ☐ Yes, please add details

Medications	☐ Latex ☐ Rubber	☐ Tapes ☐ Lotions ☐ Food
	Other	

Current Medications	Dose	Freq	Current Medications	Dose	Freq

A medication summary report from your Doctor can be attached

Have you recently taken the following medications? ☐ No ☐ Yes (please tick)

Blood thinning / Aspirin based Anti Inflammatory, Arthritis	Cortisone / Steroids /Warfarin	Have you ceased this medication for the procedure? ☐ No ☐ Yes

Past Anaesthetic Details	No	Yes	Details
Have you or a relative ever had a reaction to an anaesthetic?			
Have you ever had a blood transfusion?			

Lifestyle	No	Yes	Details
Do you smoke tobacco/cigarettes?			No.per day________Ex-Smoker (date ceased) ________
Do you consume alcohol?			☐ Daily ☐Weekly Quantity ______________
Do you require a special diet?			

Do you wear: ☐ Contact lenses ☐ Glasses ☐ Hearing Aids ☐ Dentures ☐ Other ________________________

Creutzfeldt Jacob Disease (CJD)	No	Yes
Have you had a dura mater graft prior to 1989?		
Do you have a family history of CJD?		
Have you received human pituitary (growth) hormone prior to 1985?		
Have you suffered from a recent progressive dementia the cause undiagnosed?		

Infectious Disease (H1N1)	No	Yes
Have you travelled overseas lately and where to?		
Have you been back in Australia less than 14 days?		
Do you have signs and symptoms of a respiratory infection or fever?		

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MR055

Do you currently have, or ever had, any of the following complaints (please tick condition)	No	Yes
Diabetes) NIDDM Type 2 OR IDDM Type 1) Insulin dependant, Tablet, Diet controlled		
Angina / Coronary Disease / Heart Attack / any heart problems		
Cardiac Surgery / Pacemaker / Heart valve replacement (please bring pacemaker details)		
Rheumatic fever / Heart Murmur / Atrial Fibrillation		
Palpitations / Irregular heart beat		
High Blood Pressure (Hypertension)		
Asthma / Chronic Bronchitis / Emphysema / Sleep Apnoea / Hay fever		
Pneumonia / TB		
Blood clot in Legs or Lungs (thrombosis or embolism)		
Blood Disease / Bleeding or Bruising problems / Haemophilia / Anaemia		
Stroke / TIA's / Blackouts / Fits / Epilepsy / Conditions of the nervous system		
Kidney / Bladder Problems (specify)		
Heartburn / Gastric Reflux / Hiatus Hernia / Peptic or Duodenal Ulcer		
Bowel problems eg. Diverticulitis, Crohns		
Jaundice / Liver Disease / Hepatitis A / B / C		
Mental Health Condition eg. Depression, Schizophrenia, Panic Attacks, Anxiety		
Could you be pregnant or are you pregnant? If yes, how may weeks?		
Cancer diagnosis (specify)		
Have you had chemotherapy / radiotherapy?		
Recent Cold / Flu / Other infections		
Do you believe you may be at increased risk of HIV / Hepatitis?		
Do you have any health problems not covered by these questions?		
Details:		

Do you require assistance with any of the following daily activities?	No	Yes
Walking / Moving Dressing Toileting Shower / Bathing Shopping Other ____________________ Cooking / Eating Stairs in home		

Do you care for another person?	No	Yes
Frail Aged Person Disabled Person Baby / child Other_____________ Arrangements made?		

Do you receive community support, for example:	No	Yes
Meals on wheels Nursing care Social Worker Home help Home oxygen Other Lifeline Respite Care		

Do you require information regarding	No	Yes
Medical certificate Sickness benefits Workers compensation Carers certificate Centrelink Other		

Do you live

Alone With family With spouse / partner Nursing home Other ___________________

Who will be caring for you after discharge? Name:

How will you get home when you are discharged?

Self/family Public transport Taxi Ambulance Other ___________________________

Person completing this form: ____(print name)

Relative (specify relationship) Date:

Nurse -print name Designation Date