Friendly Society Private Hospital

PATIENT HISTORY

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ Other

Please read this form carefully and complete for any conditions you **have currently** or **have had in the past.** Use the space provided for any further information.

ADMISSION DETAILS

Patient History to be reviewed at each admission, if no changes record the date and admission number in this section. If changes identified complete a new MR60	**Date:**							
	Changes identified?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
	Admission No.:							
	Initials / Role:							
	Date:							
	Changes identified?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
	Admission No.:							
	Initials / Role:							

MEDICATION

Medicines taken Prior to Presentation to Hospital (Prescribed, Over the Counter, Complementary)

Administration Aid (Specify): _____ **Own medicines brought in?** ☐ **Yes** ☐ **No**

GP: ..... Community Pharmacy:.....

Medicines usually administered by: .....

Medicine	Dose/Frequency	Duration	Medicine	Dose/Frequency	Duration

Documented by: Sign: Date:

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PATIENT HISTORY

MR 60

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SURGICAL HISTORY

Operations *(please list any major operations you have had in the past)*	**Year**	**STAFF ONLY**

Anaesthetic	**Yes**	**No**	STAFF ONLY
Have you had anaesthetic? ☐ General ☐ Sedation ☐ Local ☐ Epidural/Spinal	☐	☐	
Problems following surgery? Problem:	☐	☐	Advise Anaesthetist

Cancer **Specialist/s:**	**Yes**	**No**	STAFF ONLY
Cancer Body Site:	☐	☐	
Cancer treatment ☐ Chemotherapy ☐ XRT ☐ Methotrexate Last treatment:	☐	☐	Cytotoxic Precautions / Alerts
Family history of cancer Family Member: Body Site:	☐	☐	

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Respiratory Specialist/s: Dr	Yes	No	STAFF ONLY
Bronchitis	☐	☐	
Shortness of breath	☐	☐	
Asthma	☐	☐	
Emphysema	☐	☐	
COPD	☐	☐	
Acute respiratory infection	☐	☐	
Treatment: ☐ Home Oxygen ☐ Nebuliser ☐ Puffer	☐	☐	Record on Medication Chart

Neurology Specialist/s: Dr	Yes	No	STAFF ONLY
Stroke/TIA Date: ___ / ___ / ___	☐	☐	
Multiple Sclerosis Date: ___ / ___ / ___	☐	☐	
Residual Deficits: ☐ Speech ☐ Hemiplegia ☐ Incontinence ☐ Other (Specify): _____ Residual weakness/Body Site: _____	☐	☐	
Epilepsy Last Episode: _____	☐	☐	
Parkinson's Disease	☐	☐	
Do you have any paralysis Body site affected: _____	☐	☐	
Difficulty walking/unsteady on feet Specify: _____	☐	☐	
Fall or falls within last 6 months Where: _____ When: _____ Injury: _____	☐	☐	
Are you afraid of falling? How often: _____	☐	☐	Falls Assessment Pressure Injury assessment Consider Discharge Planner
Fits/faints/"funny turns" How often: _____	☐	☐	
Speech/ swallowing problems Specify: _____	☐	☐	
Cough/ choking when eating/drinking Specify: _____	☐	☐	Refer to Dietician
Confusion Long term ☐ Acute ☐	☐	☐	
Short term memory loss	☐	☐	
Dementia Specify: _____	☐	☐	Complete 4AT Cognitive screening / assessment tool

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Endocrine **Specialist/s: Dr**	**Yes**	**No**	**STAFF ONLY**
Diabetes ☐ Type 1 ☐ Type 2 Treatment: ☐ Insulin ☐ Tablets ☐ Diet	☐	☐	
Low blood sugar	☐	☐	Blood Glucose Monitoring
Cardiovascular **Specialist/s: Dr**	**Yes**	**No**	**STAFF ONLY**
High blood pressure	☐	☐	
Chest pain, angina Specify:	☐	☐	
Heart attack Specify:	☐	☐	
Heart failure/congestive cardiac failure Specify:	☐	☐	
Cardiac devices ☐ Pacemaker ☐ Defibrillator ☐ Other - Specify:	☐	☐	
Gastro-intestinal **Specialist/s: Dr**	**Yes**	**No**	**STAFF ONLY**
Bowel disorders Specify:	☐	☐	
Hepatitis or jaundice Specify:	☐	☐	
Gastric ulcer/reflux/hiatus hernia Specify:	☐	☐	
Diarrhoea and vomiting Specify:	☐	☐	Isolation Precautions
Haematology **Specialist/s: Dr**	**Yes**	**No**	**STAFF ONLY**
Blood/bleeding disorders/bruise easily Specify:	☐	☐	
Previous blood clots/circulation disorders Specify:	☐	☐	
Anaemia Specify:	☐	☐	
Take blood thinning/arthritis/aspirin based medication? Medication: Have you ceased medication? ☐ Yes ☐ No Date last taken: / /	☐	☐	If pre-op and not ceased, notify VMO/Anaesthetist
Genitourinary **Specialist/s: Dr**	**Yes**	**No**	**STAFF ONLY**
Renal/kidney impairment	☐	☐	
Bladder disorders	☐	☐	
Type: ☐ Blood in Urine ☐ Pain ☐ Incontinence ☐ Urgency ☐ Frequency ☐ Other:	☐	☐	Falls Assessment Pressure Injury assessment

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Musculoskeletal Specialist/s: Dr	**Yes**	**No**	**STAFF ONLY**
Osteoporosis Specify:	☐	☐	
Neck and spinal problems Specify:	☐	☐	
Arthritis Specify:	☐	☐	
Pain Management Specialist/s: Dr	**Yes**	**No**	**STAFF ONLY**
Do you have any pain? ☐ New Pain ☐ Old Pain Body Site: Cause of pain:	☐	☐	Observation Chart
General Health & Wellbeing Specialist/s: Dr	**Yes**	**No**	**STAFF ONLY**
Are you 65 years or above?	☐	☐	If patient meets one or more of this criteria, Complete 4AT Cognitive screening / assessment tool
Are you 45 or over and identify as Aboriginal or Torres Strait Islander?	☐	☐	
Do you have a known cognitive impairment/dementia?	☐	☐	
Do you have a hip fracture?	☐	☐	
Have family, friends or carers raised concerns about your cognition?	☐	☐	
Do you have a severe/ terminal illness?	☐	☐	
Mental health condition Specify:	☐	☐	
Diagnosed with anxiety and/or depression Specify:	☐	☐	
Skin integrity issues ☐ Wound ☐ Broken Skin ☐ Other Skin Conditions ☐ Pressure Injury Body Site: Treatment:	☐	☐	Wound Assessment Chart Pressure Injury Assessment
Disturbed sleep patterns/sleep apnoea ☐ Sedation ☐ CPAP	☐	☐	
Do you smoke? How many per day: If no, have you in the past Date ceased: / /	☐	☐	
Drink Alcohol Standard drinks/day:	☐	☐	
Would you like a support person to visit you? ☐ Chaplain ☐ Other - Specify:	☐	☐	Notify appropriate person
Do you have any other conditions you think we should know about?	☐	☐	

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Nutrition Specialist/s: Dr	Yes	No	STAFF ONLY
Have you lost weight recently without trying? How much?	☐	☐	Nutrition Screen (MR 63) if BMI <25 Pressure Injury Assessment
Have you been eating poorly?	☐	☐	
Take a special or modified diet Specify:	☐	☐	
Weight and height Weight: kg BMI: 0.0 Height: cm			>120kg ► Refer to Physiotherapist BMI <17 or >40 Anaesthetist PAC

Infection Control Specialist/s: Dr	Yes	No	STAFF ONLY
Do you work of have you been a patient in another hospital or nursing home in the past 6 weeks Specify:	☐	☐	If yes, MRSA Screen. ☐ Nasal Swab taken
Have you ever had an infection relating to a multi-resistant bacteria ☐ MRSA ☐ VRE ☐ ESBL ☐ c Difficille ☐ Other When: Specify:	☐	☐	Isolation Precautions MRSA ☐ Nasal Swab ESBL/VRE ☐ Rectal Swab
Classic Creutzfeldt-Jacob Disease (CJD) ☐ Dura mater graft prior to 1990 ☐ Family with CJD or reviewed for CJD ☐ Medical risk letter for CJD ☐ Human pituitary / growth or fertility hormone prior to 1986 ☐ Progressive neurological illness of less than 12 months duration which has not been diagnosed	☐	☐	Notify Infection Control Coordinator or Hospital Coordinator

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ALLERGIES

Document any known allergies or sensitivities e.g. medications, anaesthetics, latex, sticking plaster, iodine, x-ray dyes, food allergies.

MEDICATION/ANAESTHETIC	REACTION	STAFF ONLY
		Record on ALL00 Patient Alerts & Adverse Reactions
FOOD		Record on Trendcare
OTHER		If latex allergy, enter in webPAS & notify JSU NUM

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SPECIAL NEEDS					STAFF ONLY
Primary Language:			Interpreter Required ☐ Yes / No ☐		Arrange Interpreter
Special Needs:	☐ Visual aids:	☐ Glasses	☐ Contact Lenses	☐ Eye Prosthesis	
	☐ Walking aids:				Falls Assessment
	☐ Hearing aids:	☐ Left	☐ Right		
	☐ Dentures:	☐ Upper	☐ Partial	☐ Full	
		☐ Lower	☐ Partial	☐ Full	
	☐ Other:				

ENDURING POWER OF ATTORNEY / ADVANCE HEALTH DIRECTIVE		STAFF ONLY
☐ Enduring Power of Attorney	Name:	
☐ Advance Health Directive	Phone:	☐ Filed behind Medicolegal Divider
Please bring a copy to the hospital on admission		

DISCHARGE PLANNING		STAFF ONLY
Do you live in a: ☐ House ☐ Unit/Flat ☐ Retirement Village ☐ Nursing Home/Hostel		
☐ Live alone	Who will care for you on discharge:	
☐ Caring for someone else	Specify:	
☐ Have problems caring for yourself		Notify Discharge Planner
☐ Currently use any community services (specify below)		
☐ Nursing	Service Provider:	
☐ Home Help	Service Provider:	
☐ Meals	Service Provider:	
☐ Other	Service Provider:	Notify Services of Admission

DISCHARGE TIME IS 10AM		STAFF ONLY
☐ Can someone collect you by this time?	Name: Telephone:	Record on Discharge Checklist
☐ If not, how do you plan to get home?	Specify:	Discuss date & time with patient/carer

PATIENT OR CARER SIGNATURE

I certify that the information given is correct to the best of my knowledge.

Signature of Patient/Carer — Date

Name of Patient/Carer — Relationship of Patient

PRE ADMISSION ASSESSMENT (COMPLETED)

Signature of Clinician — Date

Name of Clinician — Designation

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ADMISSION TO HOSPITAL

History reviewed with patient/family/carer ☐

Condition at Time of Review:

Post-Operative ☐ Yes ☐ No

(If Yes, no further action. If No, complete assessment below)

Physical Appearance: ☐ NAD ☐ Pale/Sweating ☐ Dyspnoeic ☐ Cyanotic

Mental Status: ☐ Orientated ☐ Vague ☐ Confused Other: _____

Emotional Status: ☐ Calm ☐ Somewhat Distressed ☐ Very Distressed Other: _____

Other: _____

Signature of Clinician | Date

Name of Clinician | Designation | Unit

Save this form as a PDF and email it back to admissions@fsph.org.au

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