Molechecks Australia / Bedford Medical Clinic / Bedford Day Surgery

1284 South Road, TONSLEY SA 5042

Ph: 8277 6457 Fax: 8374 3938

PATIENT PRE THEATRE HISTORY FORM

TITLE _____ **FIRST NAME** _____ **SURNAME** _____

BIRTH DATE _____

Referral GP NAME _____ **Referral GP PHONE (if not from Bedford)**_____

Referral GP ADDRESS (if not from Bedford)_____

SPECIALIST (If Applicable) _____

ADVANCED CARE DIRECTIVES _____ Yes / No

If you circle yes, the nurse will speak with you to ensure that your requests are respected whilst under our care.

Please answer the following questions. If you answer YES to any of the following, please give details.

Do you have any **MEDICAL CONDITIONS**? _____ Yes / No

If yes, please describe _____

_____

Do you have any **ALLERGIES**? (Including allergies to bandages)_____Yes / No

Have you had any **HEART CONDITIONS**? _____Yes / No

Are you taking **ANY MEDICATIONS**? _____ Yes / No

Do you take **BLOOD THINNING MEDICATIONS,** such as **ASPRIN** or **WARFARIN**

or **ELIQUIS, XARELTO** or **PRADAXA**?_____ Yes / No

Are you **PREGNANT**? _____Yes/No/NA

Are you **BREASTFEEDING**? _____Yes/No/NA

Have you had any complications with **LOCAL ANAESTHETIC** previously? _____ Yes / No

Do you have any history of **SCARRING** problems? _____ Yes / No

Do you have a current or chronic infection such as **Staph**, **MRSA**, **VRE**? _____ Yes / No

Have you travelled and stayed in the UK or ASIA for a total of 6 months during 1980-1996? _____ Yes / No

Have you been offered to read The Australian Charter of Health Care Rights_____Yes / No

Do you have a pressure injury? _____Yes/No/NA

Have you had a fall in the last 12 months?_____ Yes / No

Do you or have you ever suffered from:

Diabetes	Yes / No	**Chest Pain**	Yes / No	**Hep B**	Yes / No
Hep C	Yes / No	**AIDS**	Yes / No	**HIV**	Yes / No
Fainting	Yes / No	**TB**	Yes / No	**Keloid scarring**	Yes / No