BEDFORD

PATIENT PRE-THEATRE HISTORY

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

BIRTH DATE _____ **DATE OF PROCEDURE**_____

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 yes, please provide the name and contact number for person who can access this document if needed

Name _____ Contact _____

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 **MENTAL HEALTH ISSUES**? _____ Yes / No

If yes, please describe _____

Do you have any **ALLERGIES**? (Including allergies to adhesives or dressings)_____Yes / No

If yes, please specify _____

Do you have any **HEART CONDITIONS**? _____Yes / No

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

Do you take **BLOOD THINNING MEDICATIONS,** such as **ASPRIN**, **WARFARIN, ELIQUIS, XARELTO, PRADAXA or FISH OIL**? _____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 a history of **DEMENTIA** or **EPISODES of DELIRIUM?** _____ Yes / No

If yes, please describe_____

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

Have you read The Australian Charter of Health Care Rights (refer back page)? _____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	**Back Injury**	Yes / No
Fainting	Yes / No	**Melanoma**	Yes / No	**Keloid scarring**	Yes / No