BOND DAY HOSPITAL

PATIENT REGISTRATION AND MEDICAL HISTORY FORM

Insert patient ID label

Specialist: …… **Procedure:** ……..

PERSONAL DETAILS

Title: Dr / Mr / Mrs / Ms / Miss Sex: M / F

Surname: …… Given Names: ……..

Preferred Name: ……

Date of Birth: …… Country of Birth: ……

Address: . …… Post Code: ……

Home Phone: …… Mobile Phone: ……

Email: ……

Medicare Number: …… Position on Card: ……. Expiry date: ……..

Health Fund Name: …….. Membership Number: ……

Language spoken at home: …… Religion: ……

Marital Status: Married / Single /Divorced / Widowed / Separated / De Facto

Indigenous Status: ☐ Aboriginal ☐ Torres Strait Islander ☐ Neither ☐ Decline to answer

Do you live alone: Y/N Are you the sole carer for someone else: Y/N

Special dietary requirements: Y/N Details: ……

EMERGENCY CONTACT / SUPPORT PERSON (Who will be taking you home)

Surname: …… Given Names: ……

Relationship: …… Telephone No: ……..

PRIVACY CONSENT

I consent to Bond Day Hospital accessing relevant information about my medical condition or history from other health care providers. I understand that to provide the highest quality medical care, my clinical records may be accessed by clinicians of this hospital and, in some circumstances, other health care providers, and as required by law. I understand that my information will be handled in accordance with the Privacy Act 1988 and relevant amendments.

CONFIRMATION

I confirm that the information provided in my registration and medical history are correct to the best of my knowledge

Signature: …… Date: ……

BOND DAY HOSPITAL

PATIENT REGISTRATION AND MEDICAL HISTORY FORM

Insert patient ID label

Height (cm)		**Weight (kg)**	

ALLERGIES (medications, food, latex)

Medication/Allergen	Type of Reaction	Medication/Allergen	Type of Reaction
……	……	……	……
……	……	……	……
……	……	……	……

CURRENT MEDICATIONS (prescription & over the counter)

Name	Purpose	Dose/Frequency	Name	Purpose	Dose/Frequency
……	……	……	……	……	……
……	……	……	……	……	……
……	……	……	……	……	……

ANAESTHETIC / RESPIRATORY

Previous reaction to anaesthetics Y/N
Asthma/emphysema/bronchitis Y/N
Sleep apnoea/CPAP machine Y/N
Drink alcohol Y/N
How many/day?
Smoker Y/N
How many/day
How many years
Past smoker Y/N
When stopped
How many years Details:

CARDIOVASCULAR / NEUROLOGICAL

High blood pressure Y/N
Heart disease/pain Y/N
Stroke/TIA Y/N
Palpitations/arrhythmias Y/N
Bleeding tendency Y/N
Fainting/blackouts Y/N
Heart valve replacement Y/N
Anaemia Y/N
Epilepsy/seizures Y/N
Pacemaker/implantable defibrillator Y/N
Do you take blood thinning medication? Y/N
Details:

GENERAL

Previous delirium Y/N
Dementia/Cognitive Impairment Y/N
Arthritis Y/N
Anxiety/depression Y/N
Other mental health condition Y/N
Advance Care Directive Y/N
Pressure injuries Y/N
Recent fall/fear of falling Y/N
Any implants Y/N
Diabetes Y/N
Controlled by: diet tablet injection
Vision or hearing impairment Y/N
Mobility impairment Y/N Details:

GYNAECOLOGICAL

……
……

INFECTION

Cold/respiratory infection/sore throat in last 4 weeks Y/N
MRSA/VRE/C Diff Y/N
Tuberculosis Y/N
Any other infections Y/N

OTHER

Previous operations

……
……