



BOND DAY HOSPITAL

**PATIENT REGISTRATION AND
MEDICAL HISTORY FORM**

Insert patient ID label

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
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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			
.....			
.....			