Noosa Surgical and Endoscopy Centre

Patient Health Assessment Form

Surname:
First Name:
Date of Birth:
Address:
MRN:

Please read questions carefully and place a tick in the appropriate boxes.

Have you had a **Heart Attack** in the last 6 months?	☐yes ☐no
Are you taking the medication **insulin**?	☐yes ☐no
Do you have a major physical **disability**?	☐yes ☐no
Your Weight : **Your Height:** **Is your weight over 120 kgs?**	☐yes ☐no
Have you ever been treated for a multi resistant organism e.g. **MRSA / VRE/CRE / hospital acquired infection?**	☐yes ☐no
Is it possible you are **pregnant** or **breastfeeding** at the moment?	☐yes ☐no
Are you taking any blood thinning medication e.g **Warfarin** / **Plavix** / **Iscover** / **Effient** / **Pradaxa** / **Eliquis** / **Xarelto** / **Brilinta or are you taking the medication Sotacor?**	☐yes ☐no
Have you been hospitalised overseas in the last 12 months ?	☐yes ☐no
Have you received **Human Growth Hormone** or **Gonadotrophine or** had **Neurosurgery** between 1972 and 1989**?**	☐yes ☐no

If you answered yes to any of the above questions you will need to arrange for a consultation with Dr Lancaster prior to the day of your procedure.

Please tick if you have had any of the following:

Heart trouble / Angina		Diabetes		Smoker	
Troublesome Asthma		Tuberculosis		Persistent Bleeding	
Renal (Kidney) impairment		Hepatitis / HIV		Need assistance in walking	
Rheumatoid Arthritis		Stroke		Joint Replacement metal implant	
High blood pressure		Epilepsy		Pacemaker / stent	

If you ticked yes to any of the above, please give details of your condition:

Please list your regular medications including herbal preparations, vitamins and complementary medicines:

Please document below any known allergies or sensitivities e.g. medications, sticking plaster, iodine, x-ray dyes, seafood, eggs, peanuts or fruit.

You are required to have adult supervision for 12 hours following your procedure. Have you arranged this? ☐yes ☐ no

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

Name (print): _____ **Date:** _____ **Signature:**_____

Relationship to the patient if not completed by patient:

Please mail the completed form to Noosa Surgical and Endoscopy Centre, P.O. Box 350, Noosaville Q 4566

Do not write in this space.

Form 3 – Patient Health Assessment Form

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