sportsmed
PREVENTION • TREATMENT • REHAB

Office use only

Affix patient identification label in this box

U.R. No.

Temp U.R.

PATIENT HEALTH HISTORY FORM (PRE-CONSULTATION)

PERSONAL INFORMATION		
Surname	Given Name	Date of birth ⌊⌋⌊⌋/⌊⌋⌊⌋/⌊⌋⌊⌋
Home address		Postcode

OFFICE USE ONLY **Height**	**Weight**	**BMI**	**Date**	**Notify Surg >150kg**

Please tick box and attach separate sheet for any lists below if required.		**Details/Specify**	**Staff Use / Initial Actions**
Have you previously been admitted to SPORTSMED·SA Hospital or Day Surgery?	☐ Yes ☐ No		
Do you have any allergies or sensitivities to medicines, tapes, foods, latex, other?	☐ Yes ☐ No	Specify allergy and reaction:	Notify Anaes Chef / HCO
Have you ever had a blood clot in your legs (DVT) .or lungs (PE)?	☐ Yes ☐ No	Please specify:	
Do you have any family history of blood clots?	☐ Yes ☐ No	Please specify:	
Are you currently taking any medications to prevent blood clots or "blood thinners"?	☐ Yes ☐ No	Please specify:	Notify as approp
Do you have any heart problems? e.g. heart attack, heart surgery, angina, pacemaker, stents Pacemaker model no:	☐ Yes ☐ No	Details: Specialist:	
Are you currently taking any medications relating to a cardiac condition?	☐ Yes ☐ No	Please specify:	Notify as approp
Do you have diabetes?	☐ Yes ☐ No	Diet: Tablets: Insulin: Type:	Notify Chef
Could you be pregnant?	☐ Yes ☐ No		Notify as approp
Do you have a history of falls?	☐ Yes ☐ No	Please specify:	
Do you or have you ever smoked?	☐ Yes ☐ No	Number per day: Date stopped:	
Do you drink alcohol?	☐ Yes ☐ No	Amount per day:	
Do you use recreational or alternative drugs?	☐ Yes ☐ No	Type: List below	
Have you ever had an infection following surgery? (include MRSA, VRE, C-Diff)	☐ Yes ☐ No	Details (year etc.):	Notify IC / Surg if approp
What are your sport, leisure, physical activities?	☐ Yes ☐ No		

PAST MEDICAL AND SURGICAL HISTORY.
Please list all previous serious illnesses, operations and the years you had them including any implants or prosthesis in your body. Please include any previous surgery to limb being operated on first.

MEDICATION HISTORY
Please list all medicines that you are currently taking including those to be stopped prior to surgery. For example: Aspirin, Warfarin, anti-inflammatory, steroids, contraceptive pill, and alternative medicines (e.g. fish oil). (Please attach a list if not enough room or you have one from your GP)

Medication	Dose & Directions	Medication	Dose & Directions	Notify Surg / Anaes if approp

PRE-CONSULTATION PATIENT HEALTH HISTORY