

PRE ADMISSION SERVICE
QUESTIONNAIRE

Patient to Complete

UR NUMBER.....

SURNAME.....

GIVEN NAMES.....

DATE OF BIRTH.....

Please fill in if no Patient Label available

PLEASE COMPLETE FOLLOWING 3 PAGES OF THIS QUESTIONNAIRE ACCURATELY.

Incomplete or unreturned forms will cause your surgery to be delayed.

You may wish to ask a family member, friend or carer to help you. If you require further information, your local Doctor may be able to assist. To contact the Pre Admission Service - phone 9784 7340, during business hours.

Please complete this section carefully. It is important to give an ACCURATE weight and height to avoid unnecessary cancellation.

How old are you? What is your weight..... kgs or.....stone

What is your height..... cms or.....feet and inches

Has your weight changed much in the last 3 months ☐ No ☐ Yes - increase / decrease

OFFICE USE ONLY

BMI
(BMI > 35 not suitable for Rosebud)MEDICATIONS: Please list all medications you are taking including any drugs or medicine not prescribed by a doctor:

NAME	DOSE	FREQUENCY	NAME	DOSE	FREQUENCY
Lyrical	300mg	1-0-1			
Cymbalta	60mg	1-0-0			
Palexia	100mg	1-0-0			
Endep	10mg	0-0-2			

- FOR COMPLETION BY PATIENT -
MEDICATIONS

ALLERGIES

ALLERGIES

Are you allergic to any Medications?

☒ No ☐ Yes

Are you allergic to Latex or rubber products?

☒ No ☐ Yes

Are you allergic to anything else?

e.g. bandaids, tapes, food etc.

☒ No ☐ Yes

Medicine or Product

What reaction

SURGICAL HISTORY

SURGICAL HISTORY

SURGERY	YEAR	SURGERY	YEAR

Please ✓ boxes as appropriate. If you answer Yes to any questions, please give as much information as possible.
You may attach a separate piece of paper if you need to write more information.

Do you have or have you ever had any of the following

CARDIAC

- High blood pressure
- Angina or chest pain,
 - How often do you get angina?
 - Do you get angina during activity or exercise?
 - Do you get angina when resting or at night?
- Heart attack
- Palpitations or irregular heart beat
- Insertion of heart valve, coronary stent or pacemaker (specify)
- Rheumatic fever

No

Yes

☐☒

When 2 months ago

☐☐

If no go to Question 3

No

Yes

☒☐

When

☒☐

When

☒☐

When

☒☐

When