

Name: _____ Date: _____

Date of Birth: _____ Sex: M F U Ht: _____ Wt: _____

Address: _____ Phone: _____

Email Address: _____ Skype Address: _____

Referring Practitioner: _____ General Practitioner: _____ Physiotherapist: _____

Medicare Card Number: _____ Expiry Date: _____ Reference No.: _____

Health Insurance Provider: _____ Policy Number: _____ Next of Kin: _____

Do you have any allergies to any medications? Yes No If yes, please list the medications and reactions you have below: _____

To your knowledge, do you have or have you ever had any of the following:

Respiratory Problems	Yes	No	Cardiovascular Problems	Yes	No	Neurologic Problems	Yes	No	
Recent cold, Bronchitis or Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Tremors <input type="checkbox"/> Parkinson's <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Asbestos	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Stroke <input type="checkbox"/> TIA (Mini-Stroke) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
History of Asthma or Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Year: _____	<input type="checkbox"/>	<input type="checkbox"/>	
Sleep Apnoea/Excessive Snoring	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis <input type="checkbox"/> Polio <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Use CPAP	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Weakness or Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of breath with exertion or rest	<input type="checkbox"/>	<input type="checkbox"/>	Fast Heart Beat/Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury Year: _____	<input type="checkbox"/>	<input type="checkbox"/>	
Emphysema/COPD	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack Year: _____	<input type="checkbox"/>	<input type="checkbox"/>	Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures Last: _____	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic Cough or Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>	Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculosis/year: _____	<input type="checkbox"/>	<input type="checkbox"/>	Chest Discomfort or Tightness	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo <input type="checkbox"/> Meniere's <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	Problems with arteries in the neck	<input type="checkbox"/>	<input type="checkbox"/>	Restless Leg Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	
			Poor circulation to legs & feet	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	
			Other: _____	<input type="checkbox"/>	<input type="checkbox"/>				
Haematologic Problems	Yes	No	Gastrointestinal Problems	Yes	No	Endocrine Problems	Yes	No	
History of Anaemia (low blood count)	<input type="checkbox"/>	<input type="checkbox"/>	Sickle-Cell Anaemia <input type="checkbox"/> Trait <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorder Hyper <input type="checkbox"/> Hypo <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
History of Bleeding or Bruising	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease/ Jaundice/ Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Parathyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Transfusion. Year: _____	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Phlebitis <input type="checkbox"/> Blood Clots <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GI Bleed/Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Adrenal Disorder <input type="checkbox"/> Pituitary <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Von Willebrand Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hiatal Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	Reflux	<input type="checkbox"/>	<input type="checkbox"/>				
			Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Urology Problems	Yes	No	
Psychological Problems	Yes	No	Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	
Anxiety <input type="checkbox"/> Depression <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	IBS <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged Prostate	<input type="checkbox"/>	<input type="checkbox"/>	
Panic Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Gastroparesis	<input type="checkbox"/>	<input type="checkbox"/>	Dialysis Peritoneal <input type="checkbox"/> Haemo <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anorexia <input type="checkbox"/> Bulimia <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>	Stress Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	
Post-Traumatic Stress	<input type="checkbox"/>	<input type="checkbox"/>	Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Tract Infections	<input type="checkbox"/>	<input type="checkbox"/>	
Alzheimer's <input type="checkbox"/> Memory Loss <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	Interstitial Cystitis	<input type="checkbox"/>	<input type="checkbox"/>	
Dementia <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				Urinary Frequency	<input type="checkbox"/>	<input type="checkbox"/>	
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	Dental Problems	Yes	No	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	
Bipolar	<input type="checkbox"/>	<input type="checkbox"/>	Caps <input type="checkbox"/> Crowns <input type="checkbox"/> Implants <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Needle Phobia	<input type="checkbox"/>	<input type="checkbox"/>	Dentures: Full <input type="checkbox"/> Partial <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Developmental Problems	Yes	No	
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	Veneers <input type="checkbox"/> Bondings <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intellectual Impairment	<input type="checkbox"/>	<input type="checkbox"/>	
			Braces <input type="checkbox"/> Retainers <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Learning Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal Problems	Yes	No	Loose where: _____	<input type="checkbox"/>	<input type="checkbox"/>	Autism	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic Pain: Neck <input type="checkbox"/> Back <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chipped where: _____	<input type="checkbox"/>	<input type="checkbox"/>	ADHD	<input type="checkbox"/>	<input type="checkbox"/>	
TMD / Jaw Problems	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	
Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>							
Osteoporosis <input type="checkbox"/> Osteopenia <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems	Yes	No	Other Problems	Yes	No	
Arthritis:	<input type="checkbox"/>	<input type="checkbox"/>	Rashes <input type="checkbox"/> Rosacea <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer Where: _____	<input type="checkbox"/>	<input type="checkbox"/>	
Type: RA <input type="checkbox"/> OA <input type="checkbox"/> Gout <input type="checkbox"/>			Open Wounds Where: _____	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	
Location: _____			Eczema <input type="checkbox"/> Psoriasis <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	MRSA	<input type="checkbox"/>	<input type="checkbox"/>	Women Only	Unsure	Yes	No
			Shingles	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear/Eye Problems	Yes	No	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	Are you breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Impaired	<input type="checkbox"/>	<input type="checkbox"/>	Infectious/Communicable Disease	Yes	No	Are you menopausal?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deaf	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>				
Use of Hearing Aids	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>				
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>				
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>				
Blindness	<input type="checkbox"/>	<input type="checkbox"/>							
Visual Impairment	<input type="checkbox"/>	<input type="checkbox"/>							
Contact Lenses <input type="checkbox"/> Glasses <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>							

Please list all previous surgeries or procedures which required anaesthesia and dates these were performed:

Have you had any problems with anaesthesia in the past? Yes No

If yes, please explain: _____

Have any of your relatives (parent, grandparents, siblings) had a problem with anaesthesia in the past? Yes No

If yes, please explain: _____

Do you have a religious or moral objection to medically recommended blood transfusions? Yes No

If yes, please explain: _____

<p style="text-align: center;">Advanced Health Directive</p> <p>Do you have an Advanced Directive (Living Will)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you an organ donor? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have a medical Power of Attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, who/relationship: _____</p>	<p style="text-align: center;">Pain Screening</p> <p>1. Do you have a chronic problem with pain? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">If yes, where is your pain located? _____</p> <p>2. Rate the severity of your pain: _____</p> <p style="text-align: right;">(0 = no pain, 10 = severe pain)</p>
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Nutritional Screening

Are you on any special diet? Yes No - Diabetic Renal Cardiac Other _____

Have you had any unintentional weight loss of more than 5kg over the past 3 months? Yes No

Have you been eating poorly because of a decreased appetite? Yes No

Are you vegetarian? Yes No Are you on a Keto diet? Yes No

Activity Screening

How many times a week, do you usually do 20 minutes or more of vigorous physical activity that makes you sweat or puff and pant? (e.g. jogging, heavy lifting, digging, aerobics, or fast cycling). > 3 times/week 1-2 times/week None

How many times a week, do you do 30 minutes or more of moderate physical activity or walking that increases your heart rate or makes you breath harder than normal? (e.g. mowing the lawn, carrying light loads, cycling at a regular pace, playing doubles tennis)

> 5 times/week 3-4 times/week 1-2 times/week

Substance Screening

<p>Have you ever smoked? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you currently smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What do you smoke?</p> <p style="padding-left: 20px;">Cigarettes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">Vaping/E-Cigarettes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">Cigars <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">Marijuana <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, how much/day? _____</p> <p>Total number of years smoked? _____</p> <p>When did you quit smoking? _____</p>	<p>Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">If yes, how many standard drinks / day? _____</p> <p>Are you a recovering alcoholic? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">If yes, how long? _____</p> <hr/> <p>Do you use recreational or IV drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">If yes, type, duration and frequency: _____</p> <hr/> <p>Do you drink caffeinated beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">If yes, how many / day? _____</p>
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Current Medication List

Please include insulin, oxygen, inhalers and any over-the-counter medications including aspirin, vitamins, herbs, minerals and supplements

Medication	Dose	Freq	Purpose	Breakfast	Lunch	Dinner	Bed
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you had any blood tests performed in the last 6 months? Yes No If yes, which pathology company? _____

Please list any specific concerns or questions you wish to discuss with your anaesthetist: _____

Are you happy for a copy of all reports and evaluations performed by Recovery Medical to be provided to your referring doctor, surgeon, anaesthetist and hospital?
 Yes No

Patient signature / name: _____ Date: _____