MR9F

09/18

Epworth

PATIENT HEALTH HISTORY - MATERNITY

Affix Patient Identification Label

Unit Record Number ....

Surname ....

Given name ....

D.O.B. .... Age .... Sex..........

Medical Practitioner ....

HEALTH INFORMATION

Full name:

Date of birth:

Today's date:

Reason for admission:

Surgical history:

Do you have an Advance Care Directive? If Yes, please bring a copy of the paperwork with you to the hospital. ☐ Yes ☐ No

Height: Pre-pregnancy weight:

Waist circumference:

Primary language spoken:

Do you require an interpreter?	☐ Yes ☐ No
Do you have diabetes: Type 1 / Type 2?	☐ Yes ☐ No
Is your diabetes managed by:	☐ diet ☐ tablets ☐ N/A ☐ insulin
Do you have gestational diabetes?	☐ Yes ☐ No
Do you have high/low blood pressure?	☐ Yes ☐ No
If 'yes', controlled by medication?	☐ N/A ☐ Yes ☐ No

Nutrition information

Do you require a special diet? Please specify:	☐ Yes ☐ No
Do you have speech or swallowing difficulties?	☐ Yes ☐ No

LIFESTYLE

Please tick and specify frequency if you:

Drink alcohol?	☐ Yes ☐ No
Smoke?	☐ Yes ☐ No
Have ever smoked?	☐ Yes ☐ No
Use recreational drugs?	☐ Yes ☐ No

ALLERGIES

Any allergies to:	If 'yes', please specify:
☐ No known allergies	
☐ Anaesthetics (self/ family)	
☐ Blood products	
☐ Chemotherapy	
☐ Food	
☐ Medication	
☐ Rubber/ latex	
☐ Tapes/ lotions	
☐ Other	

HEALTH HISTORY

Answer all questions and circle as needed:

Anaemia	☐ Yes ☐ No
Arthritis (location and type)	☐ Yes ☐ No
Asthma/ bronchitis	☐ Yes ☐ No
Auto immune disease	☐ Yes ☐ No
Bladder problems / incontinence	☐ Yes ☐ No
Blood / clotting problems	☐ Yes ☐ No
Blood transfusion	☐ Yes ☐ No
Cancer (record type and location below)	☐ Yes ☐ No
Chemotherapy / radiotherapy	☐ Yes ☐ No
Colitis	☐ Yes ☐ No
Current wounds or breaks to skin	☐ Yes ☐ No
Epilepsy / fits / seizures (date last seizure)	☐ Yes ☐ No
Heart problems (chest pain, heart attack)	☐ Yes ☐ No
Herpes- genital	☐ Yes ☐ No
History of multi-resistant infection (e.g.: MRSA / VRE / CRE / ESBL)	☐ Yes ☐ No
Hospitalisation overseas within last 12 months	☐ Yes ☐ No
Impairment: vision / hearing	☐ Yes ☐ No
Aids used?	☐ Yes ☐ No
IVF pregnancy	☐ Yes ☐ No
Kidney disease	☐ Yes ☐ No
Mastitis	☐ Yes ☐ No
Multiple pregnancies	☐ Yes ☐ No
Neck or back problems	☐ Yes ☐ No
Pelvic problems	☐ Yes ☐ No
Physical disability / mobility issues	☐ Yes ☐ No
Placenta Praevia	☐ Yes ☐ No
Pneumonia	☐ Yes ☐ No
Post natal depression	☐ Yes ☐ No
Pre-eclampsia	☐ Yes ☐ No
Psychiatric problems (anxiety / depression)	☐ Yes ☐ No
Recent cortisone treatment	☐ Yes ☐ No
Rheumatic fever	☐ Yes ☐ No
Shortness of breath or pain while exercising	☐ Yes ☐ No
Spinal problems	☐ Yes ☐ No
Strokes / ministrokes / TIA	☐ Yes ☐ No
Any residual weakness?	☐ Yes ☐ No
Thyroid problems	☐ Yes ☐ No
History of chicken pox or vaccination	☐ Yes ☐ No
History of measles or vaccination	☐ Yes ☐ No

Provide extra information or list any other health issues you have:

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MEDICATIONS

Please list ALL medications you are currently taking: prescribed, over the counter & complementary medicine (including vitamins & supplements):

Medication	Dose	Frequency	Medication	Dose	Frequency

Please bring all your listed medications with you in the original packaging, as well as any repeat / authority prescriptions, safety net and concession cards.

Have you been instructed to stop any medications prior to your admission? ☐ Yes ☐ No

Do you take or have you recently taken blood thinning medications? ☐ Yes ☐ No

Have you taken steroids or cortisone tablets or injections in the last 6 months? ☐ Yes ☐ No

If you are taking oral contraception medication, please speak with you surgeon or anaesthetist

CREUTZFELDT JAKOB DISEASE

Did you receive pituitary hormone for infertility or Human Growth Hormone prior to 1986? ☐ Yes ☐ No

Have you had brain or spinal surgery before 1990 that involved dura mater grafting? ☐ Yes ☐ No

Is this admission related to rapid onset dementia? ☐ Yes ☐ No

Do you have CJD or do you have **two or more** first degree relatives with CJD? (i.e. mother, father, sibling) ☐ Yes ☐ No

Have you been assessed for CJD or do you have a "medical in confidence letter" regarding your risk of CJD? ☐ Yes ☐ No

DISCHARGE PLAN

How are you getting home? ______________________________

Who is accompanying you home? ______________________________

Name: ______________________ Contact no. ______________________

VALUABLES

PLEASE DO NOT BRING ANY VALUABLES INTO HOSPITAL

I am aware that any valuables (including jewellery, cash, credit cards, computer equipment, mobile phones or other items of personal property with a high monetary value) I bring to hospital or decide to keep with me during my admission are my responsibility and I understand that the hospital is not liable for any losses of my personal property.

Name: Signature: Date:

Preadmission nurse name:		Signature:		Designation:		Date:	
Admitting nurse name:		Signature:		Designation:		Date & time admitted:	

ADDITIONAL COMMENTS

-Check the MR1 Admission Details for Medical Treatment Decision Maker or Medical Power of Attorney information.

- Update A1 Alert Card & iPM (eg: ACD, Medical Treatment Decision Maker, Allergies)