



Please return to
EYE ▲ TECH Day Surgeries
 Level 5 St Andrews Place,
 North Street, Spring Hill QLD 4000
Phone (07) 3831 4244
Toll free 1800 657 274
 Fax (07) 3831 4266
 Email:reception@eyetech.com.au

Family Name: _____ DOB: _____
 Given Names: _____
 Address: _____
 Postcode: _____ Admission Date: _____
 Surgeon: _____

EYE ▲ TECH Day Surgeries

**PLEASE READ QUESTIONS CAREFULLY & COMPLETE BOTH SIDES OF THIS FORM.
 ATTACH SHEET IF PROVIDING ANY FURTHER INFORMATION.**

DO YOU HAVE, OR HAVE YOU IN THE PAST, HAD A PROBLEM WITH?

Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Insulin <input type="checkbox"/> Tablets <input type="checkbox"/> Diet
Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart Attack(s)/Chest Pain/Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	When: _____
Other Heart Problems/Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	
TB/Bronchitis/Asthma/Emphysema/COPD/ Shortness of Breath/Bronchiectasis/Asbestosis/ Sleep Apnoea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use: <input type="checkbox"/> Nebulisers <input type="checkbox"/> Puffers <input type="checkbox"/> Home Oxygen <input type="checkbox"/> CPAP Used
Anaemia/Bleeding/Bruising	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specify: _____
Previous Blood Clots/Stroke/TIA's	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specify: _____
Hepatitis A / B / C	<input type="checkbox"/> Yes <input type="checkbox"/> No	
HAI / Communicable Diseases	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specify: _____
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Last Fit: _____
Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diagnosed: _____
Arthritis/Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Reflux	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Present or previous eye problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Medical Condition/s:	Treating Specialist/s:

INFECTION CONTROL		
Have you had neurosurgery prior to 1990	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specify: _____
Have you taken human pituitary hormone (growth hormone, gonadotrophin) prior to 1986	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does anyone in your family have CJD (Creutzfeldt-Jacob Disease) ("Mad Cow Disease")	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specify: _____
Have you suffered from a recent progressive dementia (physical or mental) the cause of which is unknown?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever been given a CJD risk letter by a Doctor?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

GENERAL HEALTH & WELLBEING		
How tall are you & how much do you weigh	_____ cm	_____ kg
Do you currently smoke	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many per day? _____
If not, have you smoked in the past	<input type="checkbox"/> Yes <input type="checkbox"/> No	When ceased: _____
Do you wear hearing aids?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you take illicit drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you wear contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you drink alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ standard drinks per day/week
Do you use any walking aids:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please specify _____

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Version 6 - April 2016

Do not write in this space.

▲ Advance Health Directive

Do you have a current Advance Health Directive? Yes No Provide at your discretion.

Do you have enduring Power of Attorney – health and medical guardian? Yes No Please bring Power of Attorney only if a relative is signing the consent form on your behalf.

Do you have any particular religious/cultural need? Yes No If Yes, please specify _____

PAST SURGICAL HISTORY

Please list any Surgery/Procedures below:

YEAR	SURGERY	YEAR	SURGERY

Any problem with previous anaesthetics (self/family)

Specify:

MEDICATIONS

ALL medications and when taken (including complementary therapies) to be listed below or attach separate sheet:

DRUG	DOSE / TIME	DRUG	DOSE / TIME

ALLERGIES & SENSITIVES

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

ALLERGY / SENSITIVITY	REACTION

It is important that you do not drive after your surgery. Who will be picking you up from Hospital?

Name: _____ Contact Ph. No.: _____

You are required to have Adult Supervision for 24 hrs following your surgery/procedure. Have you arranged this? Yes No

DAY SURGERY AGREEMENT

I HAVE BEEN ADVISED OF THE SPECIAL NATURE OF DAY SURGERY AND HAVE BEEN INSTRUCTED IN THE FOLLOWING TERMS WITH REGARD TO MY UNDERGOING AN ANAESTHETIC.

1. I AGREE:

- NOT to drive a car, motorcycle, ride a bicycle or operate machinery for 24 hours after my anaesthetic.
- To be accompanied home by a responsible person.
- NOT to be on my own until the following morning.
- NOT to drink alcohol for 24 hours before and after my anaesthetic.
- To have **NO** food or fluids including water, from the time I will be advised to do so by EyeTech Staff.
FAILURE TO COMPLY WILL NECESSITATE CANCELLATION OF MY OPERATION.
- To follow the written instructions provided to me.
- NOT to make any important decisions or sign a contract within 24 hours of the anaesthetic.

2. I understand that in the event of any post operative complications arising from my surgery or anaesthetic, I should contact my surgeon or attend an Emergency Department.
3. I acknowledge that the hospital accepts no responsibility for the loss of any money or valuables I bring with me.

I CERTIFY THAT THE INFORMATION GIVEN ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE.

NAME (PRINT) _____

DATE ____ / ____ / ____

SIGNATURE _____

RELATIONSHIP TO PATIENT _____

If not completed by Patient _____