EYE▲TECH Day Surgeries

Please return to
EYE ▲ TECH Day Surgeries
22 Sanders Street
Upper Mount Gravatt QLD 4122
Phone (07) 3420 2666
Toll free 1800 750 393
Fax (07) 3420 2620
Email: southside@eyetech.com.au

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

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

INFECTION CONTROL

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

GENERAL HEALTH & WELLBEING

How tall are you & how much do you weigh	_____cm _____kg	
Do you currently smoke	☐ Yes ☐ No	If yes, how many per day? _____
If not, have you smoked in the past	☐ Yes ☐ No	When ceased: _____
Do you wear hearing aids?	☐ Yes ☐ No	
Do you take illicit drugs	☐ Yes ☐ No	
Do you wear contact lenses?	☐ Yes ☐ No	
Do you drink alcohol	☐ Yes ☐ No	_____ standard drinks per day/week
Do you use any walking aids:	☐ Yes ☐ No	If yes, please specify _____

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▲ 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 _____

Do not write in this space.