Southern Cross Specialists

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CONFIDENTIAL

Patient Health Assessment

Surname	Given Name(s)	DOB
Height cm	**Weight** kg	**BMI** kg/m²

Do you have high blood pressure?	☐ Yes ☐ No	Please list your blood pressure medication(s)
Do you have diabetes?	☐ Type I ☐ Type II ☐ No	☐ Insulin ☐ Tablets (Please list) ☐ Diet control only
Do you have any heart problems?	☐ Yes ☐ No	Please list your heart medication(s)
Do you have a pacemaker, internal defibrillator, or other implanted device?	☐ Yes ☐ No	Please identify your cardiologist and device manufacturer
Have you ever had a blood clot in your leg (DVT) or lung (PE), or have a clotting disorder?	☐ Yes ☐ No	Please specify
Do you take any blood thinning medication?	☐ Yes ☐ No	Please specify the reason(s) for taking this medication

Please tick any of the following medications that you take:

☐ Plavix ☐ Iscover	☐ Warfarin ☐ Coumadin	☐ Pradaxa ☐ Xarelto ☐ Eliquis	☐ Astrix ☐ Cartia ☐ Cardiprin ☐ Asasantin	☐ Fish Oil ☐ Gingko Biloba ☐ Other (Specify)

HealthLink
drcosman

Peter H Cosman
BA/MB,BS, PhD, FRACS, FICS, FACS, FRSM, FCHSM
4878694B
Pancreaticobiliary Surgery
Oesophagogastric Surgery
Bariatric Surgery
Robotic Surgery
General Surgery
Medicolegal Assessment

Rasha Cosman
BSc, MB,BS, FRACP
2485619X
Medical Oncology
Consultant Physician

James Walcott
MB,BS, MS, FRACS
169186HW
Hepatobiliary Surgery
Pancreatic Surgery
General Surgery

Do you have asthma or other lung problems?	☐ Yes ☐ No	Please list medication(s) you take for this
Do you suffer from depression, anxiety, or mental health issues?	☐ Yes ☐ No	Please specify and list any medications you take for this
Have you ever been diagnosed with an antibiotic-resistant illness?	☐ Yes ☐ No	Please specify type and date of infection
Have you had a fall within the past 12 months?	☐ Yes ☐ No	Please specify date and any injuries sustained
Have you ever been diagnosed with a cancer?	☐ Yes ☐ No	Please indicate type, date of diagnosis, and treatment
Do you have any other health problems?	☐ Yes ☐ No	Please specify
Please list any previous operations		Date
Please list current medications, including strengths and dosages if known		
Please list any allergies or sensitivities		Reaction experienced
Do you drink alcohol?	☐ Yes ☐ No	Quantity and frequency
Do you smoke tobacco?	☐ Current smoker ☐ Ex-smoker ☐ Lifelong non-smoker	Amount per day: Years smoked: Date ceased:
Do you have a family history of cancer?	☐ Yes ☐ No	Please specify: