MEDICAL HISTORY

Ref: RES Fm 4c

This form is to be completed by the resident's medical practitioner and returned to:

	Ron Conn Nursing Home	33 Westminster Drive, Avondale Heights 3034	Tel: 9376 1122 Fax: 9376 8138
	McLean Lodge	1 Little Princes St, Flemington 3031	Tel: 9376 1599 Fax: 9372 6060
	Wintringham Hostel Port Melbourne	79 Swallow Street, Port Melbourne 3207	Tel: 9646 0588 Fax: 9646 0288
	Wintringham Hostel Williamstown	2 Wintringham Rd, Williamstown 3016	Tel: 9399 9833 Fax: 9399 9998
	Eunice Seddon Home	34 Potter Street, Dandenong 3175	Tel: 8792 2800 Fax: 9792 1355
	Gilgunya Village	23 Harding St, Coburg VIC 3058	Tel: 8199 1300 Fax: 8199 1359

The purpose of this report is to gain information about the resident's past and current medical condition. The next page lists conditions that are common for Wintringham's target group, and is followed by questions about treatments, medications and other specific requirements.

This medical information will enable Wintringham to assess the level of care and support that is required by the resident.

Could you please use BLOCK LETTERS when completing this form. If you have any queries, please contact the Residential Site Manager or Care Manager.

Thank you for your assistance in completing this report.

RESIDENT

Name: .....

Date of Birth: _____

MEDICAL PRACTITIONER

Name: .....

Clinic: .....

Address: .....

Suburb: ..... Postcode: .....

Tel: ..... AH Tel: .....

Pager / Mobile: _____ Locum: .....

Length of Relationship: .....

MEDICAL HISTORY

NEUROLOGICAL
- Acquired Brain Injury ☐
- Alcohol Related Brain Injury ☐
- Korsakoff's ☐
- Confusion ☐
- Memory Loss – Short Term ☐
- Memory Loss – Long Term ☐
- Dementia ☐
- Intellectual Disability ☐
- Headache / Migraine ☐
- Other .....

CNS
- Epilepsy / Fits ☐
- Huntington's Disease ☐
- Parkinson's Disease ☐
- Multiple Sclerosis ☐
- Paraplegia ☐
- Other .....

CVA Where .....
When .....

HEART / CIRCULATORY
- Angina ☐
- CCF / LVF ☐
- Hypertension ☐
- Hypotension ☐
- Peripheral Vascular Disease ☐
- Ischemic Heart Disease ☐
- Other .....

BLOOD / ENDOCRINE / METABOLIC
- Anaemia ☐
- Diabetes – NIDDM ☐
- Diabetes – IDDM ☐
- Obesity / Weight Loss ☐
- Thyroid Disorder ☐
- Other .....

RESPIRATORY
- Asthma ☐
- Bronchitis ☐
- COAD ☐
- Emphysema ☐
- Other .....

DIGESTIVE
- Constipation ☐
- Colostomy / Ileostomy ☐
- Diverticulosis / Ulcerative Colitis ☐
- Hiatus Hernia ☐
- Indigestion ☐
- Peptic Ulcer ☐
- Reflux Oesphagatic ☐
- Swallowing Difficulties ☐
- Other .....

NUTRITION
- Nutritional Deficiencies ☐
- Malnourishment ☐

LIVER / GALL BLADDER
- CLD ☐
- Cirrhosis ☐
- Gallstones ☐
- Other .....

MUSCULOSKELETAL
- Amputation ☐
- Arthritis ☐
- Back Injury ☐
- Gout ☐
- Muscular Dystrophy ☐
- Fracture – Location .....
  – Date .....
- Other .....

SKIN / WOUNDS
- **Eczema** ☐
- Leg/Foot Ulcer ☐
- Psoriasis ☐
- Ringworm ☐
- Other .....

SENSORY
- **Cataracts** ☐
- Glaucoma ☐
- Hearing Loss ☐
- Speech Impairment ☐
- Other .....

CANCER
- **Primary Cancer** .....
- Date .....
- Secondaries .....
- Date .....

INFECTIOUS DISEASE
- **Hepatitis B** ☐
- Hepatitis C ☐
- HIV / AIDS ☐
- Tuberculosis ☐
- Herpes ☐
- Shingles ☐
- Other .....

PSYCHIATRIC
- **Anxiety** ☐
- Bipolar Disorder ☐
- Depression ☐
- Personality Disorder ☐
- Schizophrenia ☐
- Other .....

SOCIAL
- **Alcohol Abuse** ☐
- **Analgesic Abuse** ☐
- Nicotine Abuse ☐
- Physical / Emotional Abuse ☐
- Other .....

FALLS ☐

MEDICAL HISTORY

GENITO / URINARY

- Chronic UTI ☐
- Renal Impairment ☐
- Urine incontinence ☐
- Other

SURGERY

Type	Date

IMMUNISATIONS

Influenza- current?	Yes	☐	No	☐
Tetanus- current?	Yes	☐	No	☐
Pneumococcus-current?	Yes	☐	No	☐

CURRENT HEALTH ISSUES

CURRENT TREATMENTS

(eg. physiotherapy, speech therapy, oxygen, pain management, TAC, etc.)

AIDS / PROTHESIS

CURRENT MEDICATIONS

	Dosage	Frequency

Side Effects

Compliance with Medication ☐ Good ☐ Poor

Assistance with Management of Medications ☐ Not Required ☐ Required

MEDICAL HISTORY

Monitoring of Regular Medications (eg. Lithium, Modicate, Vitamin B, Wafarin, etc.)

ALLERGIES

SPECIAL DIETARY REQUIREMENTS

COGNITIVE ASSESSMENT

Please include any behavioural issues.

Mentally capable of making independent decisions Yes ☐ No ☐ (If No, Please Comment)

INVESTIGATONS PENDING / REQUIRED

Please indicate if any appointments have been made, the date, and the frequency of testing.

SPECIALIST REFERRALS

SIGNATURE: **DATE:**