MEDICAL HISTORY FORM

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

	Ron Conn	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
	Port Melbourne	79 Swallow Street, Port Melbourne 3207	Tel: 9646 0588 Fax: 9646 0288
	Williamstown	2 Wintringham Rd, Williamstown 3016	Tel: 9399 9833 Fax: 9399 9998
	Eunice Seddon	34 Potter Street, Dandenong 3175	Tel: 8792 2800 Fax: 9792 1355
	Gilgunya	23 Harding St, Coburg VIC 3058	Tel: 8199 1300 Fax: 8199 1359
	Hobart	66 Alexandra Esplanade, Bellerive TAS 7018	Tel: 6251 8722 Fax: 6251 8723
	Angus Martin House - SRS	382 - 384 Nepean Highway, Frankston, VIC 3199	Tel: 8726 0333 Fax: 8726 0332
	Tom Fitzgerald	55 Wyndham Street, Shepparton VIC 3630	Tel: 5519 5680

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.

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

Wintringham

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 ☐

GENITO / URINARY

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 ☐

SURGERY

Wintringham

		Type	Date
Chronic UTI	☐		
Renal Impairment	☐		
Urine incontinence	☐		
Other			

IMMUNISATIONS

Influenza- Current?	Yes	☐	No	☐	Date of Administration:
Tetanus- Current?	Yes	☐	No	☐	Date of Administration:
Pneumococcus- Current?	Yes	☐	No	☐	Date of Administration:
Zoster Vaccine- Current?	Yes	☐	No	☐	Date of Administration:

COVID IMMUNISATIONS

COVID Vaccine Dose 1	Yes	☐	No	☐	Date of Administration:
COVID Vaccine Dose 2	Yes	☐	No	☐	Date of Administration:
COVID Vaccine Dose 3	Yes	☐	No	☐	Date of Administration:
COVID Vaccine Dose 4	Yes	☐	No	☐	Date of Administration:
COVID Vaccine Dose 5	Yes	☐	No	☐	Date of Administration:

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

Wintringham

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:**

Thank you for completing this form. Please save it and email it to intake@wintringham.org.au.