



S.A.A.D Patient Assessment Form

Patient Name.....
 Patient Address:
 DOB::.....Email:.....
 Phone:
 (M).....(hm).....(wk).....
 Health Fund.....

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Are you short of breath when lying down? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have any drug allergies? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you been a patient in hospital in the last two years? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so what was it for? | | |
| 4. Have you consulted your doctor about any illness in the last two years? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so what was it for? | | |
| 5. Have you ever had excessive bleeding requiring special treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Could you possibly be pregnant?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Could you be a potential HBV / HIV carrier?..... | <input type="checkbox"/> | <input type="checkbox"/> |

Do you have or have you ever had?

- | | Yes | No | | Yes | No |
|---------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|
| Chest pains | <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Palpitations | <input type="checkbox"/> | <input type="checkbox"/> | Liver disease (<i>i.e. jaundice</i>) | <input type="checkbox"/> | <input type="checkbox"/> |
| Oedema | <input type="checkbox"/> | <input type="checkbox"/> | Deep vein thrombosis | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Fits | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart attack | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Cough regularly | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic fever | <input type="checkbox"/> | <input type="checkbox"/> | Smoker | <input type="checkbox"/> | <input type="checkbox"/> |
| TB | <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Bronchitis | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis..... | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> |

Have you had any other serious illness?

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