AlfredHealth

UR

☐ Alfred ☐ Sandringham ☐ Caulfield

PATIENT INFORMATION AND HEALTH QUESTIONNAIRE

Family Name*		Given Name*	
Date of Birth*		Gender: ☐ Female ☐ Male	

*mandatory fields

Steps to completing this questionnaire,

1. Save questionnaire to your computer
2. Answer questions
3. **email to** electiveservices@alfred.org.au
4. **or** post to: Patient Services Centre, Alfred Health, PO Box 315, PRAHRAN VIC 3181

- To help identify any health problems that may need treatment before your procedure, it is important to select all conditions relevant to you and provide correct information.
- Alfred Health must receive this document within the next 7 days, to ensure no delay or cancellation with your procedure.
- If you have questions – call **9076 0359** between 8:00am & 4:30pm Monday to Friday
- Your GP may be able to provide assistance if you are unable to complete this questionnaire.

Clinic / Speciality attending	Select from list -->>>>

Home Address		Postcode	
Phone Mobile		Home	
Email			
Medicare Number		Expiry	
Do you need an interpreter to assist in discussing medical information			☐ Yes ☐ No
If yes, language			
Aboriginal or Torres Strait Islander	☐ Yes _____ ☐ No ☐ Not specified		
Do you have an advance care directive	☐ Yes ☐ No	If yes, provide a copy	
Do you have a Medical Treatment Decision Maker	☐ Yes ☐ No If yes, name		
Are you available at short notice	☐ Yes ☐ No		
Alternative Contact Person name			
Contact Person address			
Relationship		Phone	
GP Name		GP Phone	
GP Address			

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GENERAL MEDICAL CONDITIONS

Select ☐ for any conditions below, that you have or have had		If Yes, complete any additional details relevant
High blood pressure	☐	Managed by
Lower blood pressure	☐	Managed by
Heart attack / Angina / cardiac disease	☐	Specify
Irregular heart beat / Atrial Fibrillation (AF)	☐	Managed by
Palpitations	☐	Type
Other heart conditions	☐	List
Pacemaker	☐	Type
Heart valve replaced / stents	☐	Specify
Respiratory problems / asthma /bronchitis	☐	Do you use ☐ Nebulisers ☐ Puffers ☐ Home oxygen
Shortness of breath	☐	Specify
Tuberculosis	☐	Specify
Obstructive Sleep Apnoea (OSA)	☐	Is CPAP used ☐ Yes ☐ No
Has your OSA been diagnosed with a Sleep Study?	☐ Yes ☐ No	Where
Diabetes	☐	☐ Type 1 ☐ Type 2 ☐ Unsure Do you use ☐ Insulin ☐ Tablets ☐ Diet Managed by
Speech / swallowing problems	☐	Specify
Any recent weight loss of more than 5kg	☐	How much?
Any recent decrease in appetite	☐	Specify
Epilepsy / seizures	☐	Last seizure
Migraines / blackouts / fainting	☐	Managed by
Stroke / mini strokes (TIAs)	☐	Any weakness / symptoms
Blood clots / bleeding disorders / anaemia	☐	Specify
Blood transfusions	☐	Specify
Bowel / bladder problems / incontinence	☐	Specify
Kidney conditions	☐	Specify
Liver disease	☐	Specify
Reflux / indigestion / hiatus hernia / ulcers	☐	Specify
Mental health problems/depression/anxiety	☐	Specify
Short term memory loss/previous confusion	☐	Describe
Dementia / delirium / wandering	☐	Describe
Skin conditions / existing wounds	☐	Describe
Have you taken any prednisolone, cortisone or steroids in the last 6 months	☐	Name of medication Date last taken ____ or still taking ☐ Yes
Chronic or acute pain	☐	Describe
Cancer	☐	Body Location Date diagnosed
Females	☐	Could you be pregnant?
	☐	Are you breast feeding?
Other medical conditions or health problems *(eg family history of cancer, arthritis)*	List	

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PREVIOUS OPERATIONS / PROCEDURES / HOSPITAL STAYS

List any operations or procedures including dates and hospital where surgery was performed.
(attach a separate list if required)

ANAESTHETIC

Have you or a family member reacted to an anaesthetic? ☐ Yes ☐ No Details

Do you have any questions relating to an anaesthetic? ☐ Yes ☐ No List

Do you regularly see any specialists eg. Cardiologist. List name/s and address/s

MEDICATIONS

Do you take any blood thinning medication? ☐ Yes ☐ No Specify

Do you take any other medications? ☐ Yes ☐ No

If yes, list **all** medication / tablets / puffers / eye drops / vitamins / herbal medicine that you currently take
(attach separate list if required)

Medication Name	How much (dose)	How often each day (frequency)

HEALTH INFORMATION

What is your height in cms		What is your weight in kgs	

ALLERGIES Do you have any allergies. ☐ Yes ☐ No If yes, specify allergy and reaction

☐ Latex / rubber	
☐ Medication Lotions / solutions	
☐ Tape ☐ Food ☐ Other	

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LIFESTYLE		
Do you drink alcohol?	☐	Amount
Have you ever smoked?	☐	Current amount
		Date ceased
Do you use recreational drugs?	☐	Amount
		Type
Special diet required	☐	Specify
Impairment – vision	☐	Aids used
Impairment – hearing	☐	Aids used
Do you current have assistance with		
Walking	☐ Stick ☐ Frame ☐ Crutches ☐ Wheelchair ☐ Other	
Hygiene	☐ Council ☐ Other	
Meals	☐ Council ☐ Other	
Medication	☐ Dosette / webster ☐ Family ☐ Other	
How many stairs you can walk up without stopping?	☐ Two flights or more ☐ One flight ☐ Half a flight	

PLANNING FOR YOUR DISCHARGE FROM HOSPITAL

↔ You must have a responsible adult to collect you on discharge from hospital ↔

DISCHARGE DETAILS		
Who will collect you from hospital?	Name	
	Phone	
Who do you live with?	☐	Alone
	☐	With others*
	☐	In care facility or hostel*
If you live with *others or in a *care facility, provide details	Name	
	Phone	
Do you care for others at home	☐	Specify
Do you receive community support service	☐	Specify
Do you have someone to stay with you the night you leave hospital?	Name	
	Phone	
Where will you go on discharge	☐ Home ☐ Family ☐ Rehab ☐ Other	

In the last twelve months have you?

- Received treatment in an overseas healthcare facility ☐ Yes ☐ No
- Been informed that you have been a contact of someone with CPE*? ☐ Yes ☐ No
- Been informed that you have been a contact with someone with C. auris**? ☐ Yes ☐ No
- Have you ever been told you have CPE/ C.auris? ☐ Yes ☐ No

*Carbapenemase-Producing enterobacteriacaea
**Candida auris

I have provided complete and accurate answers to this questionnaire to the best of my knowledge.

Name of person completing form		Date	

Person/s completing this form ☐ Patient ☐ Relative/ Carer ☐ GP ☐ Other clinician

Email completed questionnaire to electiveservices@alfred.org.au

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