FBH272800

BENDIGO HEALTH

# PATIENT MEDICAL QUESTIONNAIRE

UR NO:..... MH NO:.....

GIVEN NAMES:..... SURNAME:.....

D.O.B:..... SEX:.....

MEDICARE NO:.....

GP:.....

USE LABEL IF AVAILABLE

Name of person completing the form:_____

☐ Self ☐ Guardian ☐ Carer ☐ Other – state relationship _____

Do you require an interpreter? ☐ Yes ☐ No If yes specify language:

| **Height:** | **Weight:** | **Occupation:** |
|---|---|---|

**Have you had or do you have any of the following?**

| | **No** | **Yes** | |
|---|---|---|---|
| High Blood pressure | ☐ | ☐ | |
| Chest pain or angina | ☐ | ☐ | If yes – how often? |
| Heart attack | ☐ | ☐ | If yes – when? |
| Any other heart condition e.g. heart valve, pacemaker | ☐ | ☐ | If yes – what type? |
| Cardiac Stents | ☐ | ☐ | If yes – when? |
| Troublesome shortness of breath | ☐ | ☐ | If yes – when do you get it? |
| Do you get out of breath after climbing one flight of stairs (8-10 steps) | ☐ | ☐ | |
| Can you walk up two flights of stairs without stopping? | ☐ | ☐ | |
| Chronic bronchitis or chronic cough | ☐ | ☐ | If yes – is it productive? |
| Asthma | ☐ | ☐ | If yes – please specify in medication section |
| Other lung or breathing problems | ☐ | ☐ | If yes – what type? |
| Sleep Apnoea | ☐ | ☐ | |
| Reflux of acid or food-heartburn/hiatus hernia | ☐ | ☐ | If yes – how often? |
| Diabetes | ☐ | ☐ | If yes – please specify in medication section if insulin or tablets |
| Epilepsy or fits | ☐ | ☐ | If yes – how often? |
| Stroke | ☐ | ☐ | If yes – do you have a disability? |
| Blackouts or fainting | ☐ | ☐ | If yes – when? |
| Blood clots in legs or lungs | ☐ | ☐ | If yes – when? |
| A bleeding disorder | ☐ | ☐ | If yes – what type? |
| Anaemia | ☐ | ☐ | If yes – when? |
| Kidney condition | ☐ | ☐ | If yes – what type? |
| Hepatitis or liver condition | ☐ | ☐ | If yes – what type? |
| Dementia/wandering/confusion | ☐ | ☐ | |
| Mental Health issues | ☐ | ☐ | If yes – what type? |
| **Please tick the 'No' or 'Yes' box for the following questions:** | **No** | **Yes** | |
| Are you pregnant | ☐ | ☐ | |
| Smoking status: ☐ Non ☐ Ex-smoker ☐ Current (last 30 days) ☐ Request Healthy For You support | | | |
| Do you drink alcohol | ☐ | ☐ | If yes – how much per week? |
| Do you use other substances e.g. marijuana cocaine | ☐ | ☐ | If yes – which substances? |
| Do you take vitamins | ☐ | ☐ | If yes – which vitamins? |
| Do you take herbal medication | ☐ | ☐ | If yes – which medication? |
| Do you use traditional Chinese Medicine | ☐ | ☐ | If yes – what medicines? |
| Do you have other health issues | ☐ | ☐ | If yes – what? |

PATIENT MEDICAL QUESTIONNAIRE

MR86

# PATIENT MEDICAL QUESTIONNAIRE

UR NO:..... MH NO: .....

GIVEN NAMES: ..... SURNAME: .....

D.O.B: ..... SEX: .....

MEDICARE NO: .....

GP: .....

USE LABEL IF AVAILABLE

| Please tick the 'No' or 'Yes' box for the following questions: | No | Yes | |
|---|---|---|---|
| Do you have any allergies or have you had any reactions to medications? | ☐ | ☐ | Please describe |
| Have you had blood transfusions | | | If yes – what year? |
| Have you or a family member had a serious reaction to general anaesthetic | ☐ | ☐ | If yes – what type? |
| Do you have an Advance Care Directive and/or a Medical Treatment Decision Maker (previously called Medical Enduring Power of Attorney)? | ☐ | ☐ | If yes – please attach a copy of your documents |
| Have you had any major illnesses not mentioned above | ☐ | ☐ | If yes – what? |
| Do you permit Bendigo Health to contact your GP | ☐ | ☐ | If yes – name? |

| | Don't Know | No | Yes | |
|---|---|---|---|---|
| Is there a condition that runs in the family e.g. thalassemia, muscle dystrophy | | | | If yes – what condition? |
| Have you ever been told that you have a multi-resistant organism | | | | If yes – which? |
| Did you live in the UK for a total of six months or more between 1st Jan 1980 – 31st Dec 1996 | | | | |

**Have you had any operations in the past? No Yes if yes please list them below.**

| Name of operation (Attach extra list if insufficient space) | When |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

**Please list any medications that you currently use in the list below**

| Name of medication (Attach extra list if insufficient space) | Dose (mg) | When Taken |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| Have you recently taken any of the following medication? | No | Yes | If Yes what date did you last take this? |
|---|---|---|---|
| Warfarin/Coumadin | | | |
| Blood thinning/Aspirin based | | | |
| Clopidrel/Plavix/Iscover/Apixaban/Dabigatran/Rivaroxaban/ Prasugrel/ Tricagrel | | | |
| Anti-inflammatory/Arthritis medication | | | |
| Prednisone Cortisone or other steroids | | | |

**You will need to make arrangements for someone to take you home from hospital**

**YOU WILL NOT BE ABLE TO DRIVE AFTER THIS PROCEDURE.**

**Day case patients must have an adult to accompany them home and stay overnight.**

*If you have any problem completing this form please call Patient Services Bendigo Health: 5454 8800*

*Please note: Bendigo Health participates in and is part of Australia's My Health Record system*