



Patient Health Questionnaire

Surname: _____

First Name: _____

Date of Birth: _____

Affix patient identification label here

Please complete this form as the best you can and return to Hervey Bay Surgical Hospital as soon as possible before your surgery / procedure date. (P.O Box 1125, Hervey Bay, Qld 4655)

Health and Risk Assessment – do any of the following apply?

Allergy or Adverse Reactions Yes No
Latex **Food** **Skin Prep** **Medications** **Tapes** **Other**
 Please list (attach a list if extensive)

Allergy	Reaction

(Circle if more than one choice available)	Yes	No		Yes	No
Asthma / Bronchitis			Previous blood clots		
Sleep apnoea			Blood thinning medications		
Investigative sleep studies			Heart attack / angina		
CPAP machine (please bring CPAP if staying overnight)			Artificial heart valve / implant / pacemaker / cardiac stent / defibrillator		
Epilepsy / fits / seizures			Anaesthetic difficulties		
Diabetes Insulin / Tablet / Diet			*Do you have any infected wounds?		
*History of / current Infection with multi-resistant organism? e.g. MRSA 'Golden Staph' / VRE			*Live with a person who has had an infection with a multi-resistant organism?		
*Do you live in a Nursing Home			*Had an overnight stay in another hospital in the last 3 months?		
*Do you have / had Hepatitis A / B / C HIV or Tuberculosis			*Have been exposed to a communicable disease within the last 2 weeks? eg. Chickenpox, measles, shingles		
*Do you or any members of your family have a history of Creutzfeldt-Jakob Disease (CJD) (Mad Cow Disease)?			*Receive a <i>dura mater graft</i> between 1972 and 1989 or *Receive human pituitary hormone (growth, gonadotrophin) prior 1985		

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Your Physical Health – do any of the following apply?

(Circle if more than one choice available)	Yes	No		Yes	No
High blood pressure			Liver disease / disorder		
Blood disease / disorder			Kidney disease / disorder		
Irregular heart beat or murmur			Stroke / CVA		
Gastric reflux / hiatus hernia			Neurological condition		
Significant back / neck injury			Organ failure / transplant		
Recurrent / active bladder infection			Any form of cancer		
Prostate issues			Other:		

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**Patient Health
Questionnaire**

(Affix Patient Identification Label Here)

Your Mobility and Discharge Planning – do any of the following apply?					
	Yes	No		Yes	No
Do you have any difficulty walking?			Are you a carer for someone?		
Do you require walking aides? <i>(Please bring with you on admission)</i>			Do you currently have support services in place? _____		
Have you had a recent fall?			Have you arranged transport home after your procedure?		
Do you live alone?			Have you arranged someone to care for you post operation?		

Your Personal and Emotional Health – do any of the following apply?					
	Yes	No		Yes	No
Currently or possibly pregnant?			Problems with your bowels?		
Problems with your bladder?			Eating / swallowing difficulties?		
Unexplained weight loss / gain? Current weight: _____			Any rashes / bruising / cuts / ulcers/ pressure sores?		
Anxiety or depression?			Any psychological disorders?		
Any dementia or memory loss?			Any sleeping difficulty?		
Did you or do you smoke?	Yes	No	How many per day? _____ If stopped when? _____		
Do you drink alcohol?	Yes	No	How many? _____ How often? _____		
Any vision difficulty?	Yes	No	<input type="checkbox"/> Left eye <input type="checkbox"/> Right eye <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts		
Any hearing difficulty?	Yes	No	<input type="checkbox"/> Left ear <input type="checkbox"/> Right ear <input type="checkbox"/> Hearing aid <input type="checkbox"/> lip reading		
Any dental issues?	Yes	No	<input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Denture <input type="checkbox"/> Bridge <input type="checkbox"/> Caps/crown <input type="checkbox"/> Loose/broken teeth		

Your Surgical History
Please provide details of any previous surgery / procedures you have had and when?

Your Medication Summary (including natural therapies)				
Medication	Strength	Dose	Reason for taking	Taking for how long or when ceased?

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