HERVEY BAY surgical hospital

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	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, CRE			*Have been exposed to a communicable disease within the last 2 weeks? eg. Chickenpox, measles, shingles		
*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			*Live with a person who has had an infection with a multi-resistant organism?		
*Do you or any members of your family have a history of Creutzfeldt-Jakob Disease (CJD) (Mad Cow Disease)?			*Receive a *dura mater graft* between 1972 and 1989 or *Receive human pituitary hormone (growth, gonadotrophin) prior 1985		
*Have you been on any cruise ships or travelled outside of Australia within the last 12months? If YES, where did you travel to: _____ Date you returned to Australian shores:_____					

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? *(Please bring with you on admission)*			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	□ Left eye □ Right eye □ Glasses □ Contacts
Any hearing difficulty?	Yes	No	□ Left ear □ Right ear □ Hearing aid □ lip reading
Any dental issues?	Yes	No	□ Upper □ Lower □ Denture □ Bridge □ Caps/crown □ Loose/broken teeth

Your Surgical History

Please provide details of any medical issues not identified above and 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?**

Patient Health Questionnaire MR 002