

☐ Alfred ☐ Sandringham ☐ Caulfield

PATIENT INFORMATION AND HEALTH QUESTIONNAIRE

Family Name*		Given Name*	
Date of Birth*		Sex	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other

*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 assist if you are unable to complete this questionnaire.

Clinic / Speciality attending

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

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GENERAL MEDICAL CONDITIONS			
Select <input type="checkbox"/> for any conditions below, that you have, or have had		If Yes, complete any additional details relevant	
Have you had a COVID-19 infection diagnosed in the last 3 months?	<input type="checkbox"/>	Date of positive test	
Were you admitted to hospital for anytime during your COVID-19 illness?	<input type="checkbox"/>		
Do you have ongoing symptoms? Eg, breathless/ palpitations/ chest pain/ fatigue	<input type="checkbox"/>		
Are you able to do normal daily activity as you could before COVID-19 infection?	<input type="checkbox"/>		
High blood pressure	<input type="checkbox"/>	Managed by	
Lower blood pressure	<input type="checkbox"/>	Managed by	
Heart attack / Angina / cardiac disease	<input type="checkbox"/>	Specify	
Irregular heart beat / Atrial Fibrillation (AF)	<input type="checkbox"/>	Managed by	
Palpitations	<input type="checkbox"/>	Type	
Other heart conditions	<input type="checkbox"/>	List	
Pacemaker	<input type="checkbox"/>	Type	
Heart valve replaced / stents	<input type="checkbox"/>	Specify	
Respiratory problems / asthma /bronchitis	<input type="checkbox"/>	Do you use <input type="checkbox"/> Nebulisers <input type="checkbox"/> Puffers <input type="checkbox"/> Home oxygen	
Shortness of breath	<input type="checkbox"/>	Specify	
Tuberculosis	<input type="checkbox"/>	Specify	
Obstructive Sleep Apnoea (OSA)	<input type="checkbox"/>	Is CPAP used <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has your OSA been diagnosed with a Sleep Study?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Where
Diabetes	<input type="checkbox"/>	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Unsure	
		Do you use <input type="checkbox"/> Insulin <input type="checkbox"/> Tablets <input type="checkbox"/> Diet	
		Managed by	
Speech / swallowing problems	<input type="checkbox"/>	Specify	
Any recent weight loss of more than 5kg	<input type="checkbox"/>	How much?	
Any recent decrease in appetite	<input type="checkbox"/>	Specify	
Epilepsy / seizures	<input type="checkbox"/>	Last seizure	
Migraines / blackouts / fainting	<input type="checkbox"/>	Managed by	
Stroke / mini strokes (TIAs)	<input type="checkbox"/>	Any weakness / symptoms	
Blood clots / bleeding disorders / anaemia	<input type="checkbox"/>	Specify	
Blood transfusions	<input type="checkbox"/>	Specify	
Bowel / bladder problems / incontinence	<input type="checkbox"/>	Specify	
Kidney conditions	<input type="checkbox"/>	Specify	
Liver disease	<input type="checkbox"/>	Specify	
Reflux / indigestion / hiatus hernia / ulcers	<input type="checkbox"/>	Specify	
Mental health problems/depression/anxiety	<input type="checkbox"/>	Specify	
Short term memory loss/previous confusion	<input type="checkbox"/>	Describe	
Dementia / delirium / wandering	<input type="checkbox"/>	Describe	
Skin conditions / existing wounds	<input type="checkbox"/>	Describe	

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GENERAL MEDICAL CONDITIONS *continued*

Select <input type="checkbox"/> for any conditions below, that you have or have had	If Yes, complete any additional details relevant
Have you taken any prednisolone, cortisone or steroids in the last 6 months	<input type="checkbox"/> Name of medication Date last taken or still taking <input type="checkbox"/> Yes
Chronic or acute pain	<input type="checkbox"/> Describe
Cancer	<input type="checkbox"/> Body Location Date diagnosed
Other medical conditions or health problems (eg family history of cancer, arthritis)	<input type="checkbox"/> List
Female patients	<input type="checkbox"/> Could you be pregnant? <input type="checkbox"/> Are you breast feeding? <input type="checkbox"/> Do you take hormonal contraceptive? Eg, the pill, mirena coil, vaginal ring, hormone injection

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 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

List

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LIFESTYLE	
Select <input type="checkbox"/> for YES	If Yes, complete any additional details relevant
Do you drink alcohol?	<input type="checkbox"/> Amount
Have you ever smoked?	<input type="checkbox"/> Current amount
	<input type="checkbox"/> Date ceased
Do you use recreational drugs?	<input type="checkbox"/> Amount
	<input type="checkbox"/> Type
Special diet required	<input type="checkbox"/> Specify
Impairment – vision	<input type="checkbox"/> Aids used
Impairment – hearing	<input type="checkbox"/> Aids used
Do you have current assistance with Walking Hygiene Meals Medication	<input type="checkbox"/> Stick <input type="checkbox"/> Frame <input type="checkbox"/> Crutches <input type="checkbox"/> Wheelchair <input type="checkbox"/> Other <input type="checkbox"/> Council <input type="checkbox"/> Other <input type="checkbox"/> Council <input type="checkbox"/> Other <input type="checkbox"/> Dosette / webster <input type="checkbox"/> Family <input type="checkbox"/> Other
How many stairs you can walk up without stopping?	<input type="checkbox"/> Two flights or more <input type="checkbox"/> One flight <input type="checkbox"/> 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?	<input type="checkbox"/> Alone
	<input type="checkbox"/> With others*
	<input type="checkbox"/> 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	<input type="checkbox"/> Specify
Do you receive community support service	<input type="checkbox"/> Specify
Do you have someone to stay with you the night you leave hospital?	Name
	Phone
Where will you go on discharge	<input type="checkbox"/> Home <input type="checkbox"/> Family <input type="checkbox"/> Rehab <input type="checkbox"/> Other
In the last twelve months have you? <ul style="list-style-type: none"> Received treatment in an overseas healthcare facility <input type="checkbox"/> Yes <input type="checkbox"/> No Been informed that you have been a contact of someone with CPE*? <input type="checkbox"/> Yes <input type="checkbox"/> No Been informed that you have been a contact with someone with C. auris**? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been told you have CPE/ C.auris? <input type="checkbox"/> Yes <input type="checkbox"/> No 	
*Carbapenemase-Producing enterobacteriaceae (Enterobacteriaceae) **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 <input type="checkbox"/> Patient <input type="checkbox"/> Relative/ Carer <input type="checkbox"/> GP <input type="checkbox"/> Other clinician	

Email completed questionnaire to electiveservices@alfred.org.au