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 Specify language:

Height	**Weight**

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

	No	**Yes**			
High Blood pressure	☐	☐			
Chest pain or angina	☐	☐	How often?		
Heart attack	☐	☐	When?		
☐ Cardiac stents	☐	☐	When?		
☐ Pacemaker or ICD	☐	☐	Type?		
			Where is it checked?		
Other heart disease or heart murmur	☐	☐	What type?		
Stroke	☐	☐	Disability	No ☐	Yes ☐
Asthma	☐	☐	Do you use a puffer?	No ☐	Yes ☐
Chronic cough or chronic bronchitis	☐	☐	Is it productive?	No ☐	Yes ☐
Any other lung or chest disease	☐	☐	What type?		
Diabetes	☐	☐	Do you take insulin?	No ☐	Yes ☐
			Do you take tablets?	No ☐	Yes ☐
Hepatitis	☐	☐	What type?		
Fits or Epilepsy	☐	☐	Last episode?		
Kidney condition	☐	☐			
Blood clots in legs or lungs	☐	☐	When?		
Heartburn/Indigestion/Hiatus hernia	☐	☐			
Dementia/wandering/confusion	☐	☐			
Mental Health issues	☐	☐	Comment		

Have you ever been diagnosed with sleep apnoea?	No ☐	Yes ☐
Do you get short of breath if you climb one flight of stairs (8-10 steps)?	No ☐	Yes ☐
Have you had any operations or major illness?	No ☐	Yes ☐

What are they?

	No	**Yes**	
Blood transfusions	☐	☐	What year?
Do you currently have a multi-resistant organism	☐	☐	Which?
Are you at risk of Creutzfeldt - Jakob disease (CJD)	☐	☐	

PATIENT MEDICAL QUESTIONNAIRE

MR86

July 2016

BENDIGO HEALTH

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Medications, adverse reactions and substance use:

	No	Yes	
Do you have any allergies or have you had any reactions to medications?	☐	☐	Please describe
Do you take aspirin or blood thinners regularly?	☐	☐	
Have you ever taken cortisone type medication	☐	☐	When?

Smoking status:	☐ Non	☐ Ex-smoker	☐ Current (last 30 days)	☐ Request quit support

Do you drink alcohol?	☐	☐	How much?
Do you use any other substances (eg heroin, cocaine, marijuana)?	☐	☐	Which ones?
Do you take any any of the following?			Please list
Vitamins	☐	☐	
Herbal medication	☐	☐	
Traditional Chinese Medicine	☐	☐	
Do you take any regular medication?	☐	☐	Please list below *(please attach a list of medications if space below is exceeded)*

Name of medication	Dose (mg)	When

Have you or your family had?

	No	Yes	
Serious bleeding/clotting problems	☐	☐	Please describe
Serious reaction to general anaesthesia	☐	☐	What type?
Medical problems which run in the family eg muscular dystrophy, thalassaemia	☐	☐	What type?
Females: Are you pregnant?	☐	☐	Due date?
Do you have an advance care plan?	☐	☐	
Do you permit Bendigo Health to contact your GP	☐	☐	

Discharge planning:

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