

## Patient Information Form

To help identify any health problems that may need treatment before your procedure, please answer all the questions in this form as accurately as possible.

### Personal Details

PATIENT OR GUARDIAN TO COMPLETE

Title _____	Surname _____	Given Name(s) _____
Date of Birth _____	Age _____	Sex _____
Street Address _____		
Suburb _____	State _____	Postcode _____
Home Phone _____	Mobile Phone _____	
Email _____		

### Medicare Details

Medicare Number \_\_\_\_\_ IRN \_\_\_\_\_ Expiry (MM/YYYY) \_\_\_\_ / \_\_\_\_

### Interpreter

Do you require an interpreter? ☐ YES ☐ NO If YES, what language? \_\_\_\_\_

### Power of Attorney

Do you have a medical Power of Attorney? ☐ YES ☐ NO

If YES, Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_

### Advanced Care Directive

If you have an advanced care directive, please provide written details:

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## Patient Information Form

### Next of Kin / Emergency Contact

Name	Relationship
Mobile	Other (work/landline):

### Pick-up Person / Carer

Same as Next of Kin / Emergency Contact? ☐ YES ☐ NO

If NO, provide details below:

Name	Relationship
Mobile	Other (work/landline):

### Address where you are staying after surgery

Street Address	
Suburb	Postcode

### Family / Local Doctor Details

Doctor's Name	Phone
Name of Clinic	
Street Address	
Suburb	Postcode

### Medical / Carer's Certificate

Do you require a medical and/or carer's certificate? ☐ YES ☐ NO

## Patient Health Questionnaire

### Health Information

PATIENT OR GUARDIAN TO COMPLETE

Age \_\_\_\_\_ Height (cm) \_\_\_\_\_ Weight (kg) \_\_\_\_\_

*Please attach a separate page if more room is required to answer the questions below*

### Allergies

Do you have any allergies to the following items?	NO	YES	If YES, please specify allergy and reaction:
Medications	<input type="checkbox"/>	<input type="checkbox"/>	
Latex/Rubber	<input type="checkbox"/>	<input type="checkbox"/>	
Tape/Food/Other	<input type="checkbox"/>	<input type="checkbox"/>	

### Previous Operations / Procedures / Hospital Stays

Date	Details of operation or procedure
_____	_____
_____	_____
_____	_____
_____	_____

### Previous Anaesthetic Details

Have you or a family member had a reaction to Anaesthetic? Please specify:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you or your family have a history of Malignant Hyperthermia? ☐ YES ☐ NO

Do you have any questions relating to the Anaesthetic? Please specify:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Patient Health Questionnaire

*Please attach a separate page if more room is required to answer the questions below*

### Regular Medications

Do you take any medications? This includes tablets, puffers, eye drops, vitamins and herbal medicine.

Please list below:

Name of medication	How much (dose)	How often (frequency)

### Blood Thinning Medications

Do you take any of the following blood thinning medications?

☐ Warfarin ☐ Clopidogrel ☐ Dabigatran ☐ Aspirin ☐ Plavix/Iscover

Any other blood thinners? \_\_\_\_\_

### Bisphosphonate Medication for Bone Disease or Metastatic Disease

Are you taking or have you taken any Bisphosphonate medication (e.g Fosamax, Alendronate, Risedronate, Tiludronate, Disodium Pamidromate, Zoledronic Acid, Etidronate or Sodium Clodronate) for:

☐ Osteoporosis ☐ Paget's Disease ☐ Bone Cancer, Cancer Spread to Bones ☐ Multiple Myeloma ☐ Other

If you have previously taken any Bisphosphonates:

When did you stop? \_\_\_\_\_ How long did you take them? \_\_\_\_\_

## Patient Health Questionnaire

### Dental Information

Do you have any loose teeth, dentures, crowns, bridges or dental implants? ☐ YES ☐ NO

If YES, please provide details:

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Do you have any of the following:

- Clicking or grating when you open/close your mouth? ☐ YES ☐ NO
- Limited mouth opening ☐ YES ☐ NO
- Sinus problems/Previous sinus surgery/Fractured nose ☐ YES ☐ NO
- Any complications with previous dental treatment? ☐ YES ☐ NO

If YES, please provide details:

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## Patient Health Questionnaire

### General Medical Condition

PATIENT OR GUARDIAN TO COMPLETE

Have you ever had, or do you have any of the following? Please tick YES or NO	NO	YES	If YES, please provide details:
High Blood Pressure (Managed by)	<input type="checkbox"/>	<input type="checkbox"/>	
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Attack/Chest Pain/Angina/Cardiac Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Irregular Heartbeat/Atrial Fibrillation (AF)	<input type="checkbox"/>	<input type="checkbox"/>	
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	
Other Heart Conditions (specify)	<input type="checkbox"/>	<input type="checkbox"/>	
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Type:
Heart Valve Replaced/Stents	<input type="checkbox"/>	<input type="checkbox"/>	Year:
Respiratory problems/Asthma/Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Do you use: Nebulisers / Puffers / Home oxygen
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	
Obstructive Sleep Apnoea (OSA) Has your OSA been diagnosed with a sleep study?	<input type="checkbox"/>	<input type="checkbox"/>	CPAP used?
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	If YES, <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Unsure Controlled by <input type="checkbox"/> Diet <input type="checkbox"/> Tablet <input type="checkbox"/> Insulin
Speech/Swallowing problems	<input type="checkbox"/>	<input type="checkbox"/>	
Any recent weight loss of more than 5kg	<input type="checkbox"/>	<input type="checkbox"/>	How much?
Any recent decrease in appetite	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy/Fits/Seizures/Migraines/Blackouts/Fainting	<input type="checkbox"/>	<input type="checkbox"/>	
Strokes/Mini Strokes (TIAs)	<input type="checkbox"/>	<input type="checkbox"/>	Weakness/Symptoms?
Infectious Diseases: HIV/Hepatitis/STIs	<input type="checkbox"/>	<input type="checkbox"/>	
Hospital acquired infections (VRE/MRSA)	<input type="checkbox"/>	<input type="checkbox"/>	
Creutzfeldt Jakob Disease (CJD)	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Clots/Bleeding disorders/Anaemia/ Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	
Elimination Issues: Bowel/Bladder problems	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney Condition	<input type="checkbox"/>	<input type="checkbox"/>	
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Reflux/Indigestion/Hiatus Hernia/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	
Mental Health Problems: Depression/Anxiety etc	<input type="checkbox"/>	<input type="checkbox"/>	
Short Term Memory Loss/Dementia/ Previous confusion/Delirium/Wandering	<input type="checkbox"/>	<input type="checkbox"/>	
Skin Conditions/Existing Wounds/Broken Skin	<input type="checkbox"/>	<input type="checkbox"/>	
Have you taken any Prednisolone, Cortisone or Steroids in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic or acute pain	<input type="checkbox"/>	<input type="checkbox"/>	Location: Severity:
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Details: Date Diagnosed:
Female Patients: Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>	
Other medical conditions?	<input type="checkbox"/>	<input type="checkbox"/>	

## Patient Health Questionnaire

### Lifestyle

Do you:	NO	YES	If YES, please provide details:
Drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	Amount: _____ How often: _____
Smoke tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	Cigarettes per day: _____ Year started: _____ Date ceased (if applicable): _____
Use recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>	Type: _____ Amount: _____ How often: _____
Have vision or hearing impairment?	<input type="checkbox"/>	<input type="checkbox"/>	Details: _____ Aids used: _____
Do you have assistance with: - Mobility - Hygiene - Meals - Medication	<input type="checkbox"/>	<input type="checkbox"/>	Please circle: Stick / Frame / Crutches / Wheelchair / Scooter Council / Other Council / Other Dosette / Webster / Family / Other
How many stairs can you walk up without stopping?	<input type="checkbox"/>	<input type="checkbox"/>	Two flights or more / One flight / Half a flight

### Social

Do you live:	NO	YES	Additional information (if required):
- Alone	<input type="checkbox"/>	<input type="checkbox"/>	
- With others?	<input type="checkbox"/>	<input type="checkbox"/>	
- Care Facility/Hostel?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you care for others at home?	<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____

☐ I have completed this questionnaire to my best knowledge and understand that failure to make a full disclosure may place me (or the above-mentioned patient) at undue medical risk.

Signature of Patient/Guardian: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_