AlfredHealth

UR *if known*

☐ Alfred ☐ Sandringham ☐ Caulfield

PATIENT INFORMATION AND HEALTH QUESTIONNAIRE

Last name*		First name/s*	
Date of birth*		Sex at birth ☐ Female ☐ Male ☐ Other	

*mandatory fields

Steps to completing this questionnaire,

1. Save questionnaire to your computer and answer **all** questions
2. **email to** electiveservices@alfred.org.au
3. **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	Select from list

Home address					Postcode		
Telephone		Email					
Gender identity	☐ Female ☐ Male ☐ Non binary ☐ Not stated ☐ Prefer not to answer ☐ Different term						
Preferred contact method	☐ Telephone ☐ SMS ☐ Email ☐ Letter						
Medicare number		Reference		Expiry		NDIS	
Do you need an interpreter to assist in discussing medical information	☐ Yes ☐ No						
If yes, language							
Aboriginal status	☐ Not Aboriginal or Torres Strait Islander ☐ Torres Strait Islander not Aboriginal ☐ Aboriginal not Torres Strait Islander		☐ Aboriginal and Torres Strait Islander ☐ Prefer not to answer ☐ Not specified				
Do you have an advance care directive (ACD)	☐ Yes ☐ No	If yes, provide a copy					
Do you have a Medical Treatment Decision Maker (MTDM)	☐ Yes ☐ No If yes, name Relationship	If yes, provide a copy					
Are you available at short notice	☐ Yes ☐ No						
Alternative contact person name							
Relationship		Phone					
GP name		GP phone					
GP address							

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GENERAL MEDICAL CONDITIONS

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

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GENERAL MEDICAL CONDITIONS *continued*

Select ☐ 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	☐	Name of medication Date last taken ____ or still taking ☐ Yes
Chronic or acute pain	☐	Describe
Cancer	☐	Body location Date diagnosed
Other medical conditions or health problems *(eg family history of cancer, arthritis)*	☐	List
Female patients	☐	Could you be pregnant?
	☐	Are you breast feeding?
	☐	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 ☐ for YES		**If Yes, complete any additional details relevant**
Do you drink alcohol?	☐	Amount
Have you ever smoked?	☐	Current amount
		Date ceased
Do you use recreational drugs?	☐	Amount
		Type
Special diet required	☐	Specify
Impairment – vision	☐	Aids used
Impairment – hearing	☐	Aids used
Do you have current assistance with Walking Hygiene Meals Medication		☐ Stick ☐ Frame ☐ Crutches ☐ Wheelchair ☐ Other ☐ Council ☐ Other ☐ Council ☐ Other ☐ Dosette / webster ☐ Family ☐ Other
How many stairs you can walk up without stopping?		☐ Two flights or more ☐ One flight ☐ Half a flight
Can you lie flat on a bed for 45 minutes?		☐ Yes ☐ No
How many pillows do you need when laying flat?		☐ One ☐ Two ☐ Three

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?	☐	Alone
	☐	With others*
	☐	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	☐	Specify
Do you receive community support services	☐	Specify
Do you have someone to stay with you the night you leave hospital?	Name	
	Phone	
Where will you go on discharge	☐ Home ☐ Family ☐ Rehab ☐ Other	

In the last twelve months have you?

- Received treatment in an overseas healthcare facility ☐Yes ☐No
- Been informed that you have been a contact of someone with CPE*? ☐Yes ☐No
- Been informed that you have been a contact with someone with C. auris**? ☐Yes ☐No
- Have you ever been told you have CPE/ C.auris? ☐Yes ☐No

*Carbapenemase-Producing enterobacteriacaea (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 ☐ Patient ☐ Relative/ Carer ☐ GP ☐ Other clinician

Email completed questionnaire to electiveservices@alfred.org.au

EMR: Perioperative / Procedure_Preadmission_Patient Information and Health Questionnaire

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