



HEALTH HISTORY QUESTIONNAIRE

Please complete both pages of the Health History Form, including personal details.
Thank you

Patient Name: _____ DOB: ___/___/___
 Address: _____ State: _____ Postcode: _____
 Height (cms): _____ Weight (Kgs): _____ Date you are completing this: ___/___/___

HEALTH HISTORY QUESTIONNAIRE

Q	Medical History <i>(If answered yes to any questions please clarify page 2.)</i>	Please Circle
1.	Have you or a family member had a problem with anaesthetic?	Yes No
2.	Are you allergic or sensitive to any food, medications or materials, such as Latex? If YES - please list on reverse side.	Yes No
3.	Do you take any blood thinning (anticoagulant) medication? <i>(Please do not cease medication unless advised by your surgeon)</i>	Yes No
4.	Do you have Diabetes ? If Yes are you: Insulin dependent? YES / NO if yes - Pump YES / NO Non-Insulin dependent YES / NO if yes - Tablets / Diet	Yes No
5.	Have you had or are you being treated for High or low blood pressure ?	Yes No
6.	Have you had or do you have Asthma / COPD / Emphysema or other lung disease and/or surgery ?	Yes No
7.	Do you have sleep apnoea or excessive snoring? If yes, do you use CPAP / BiPAP / VPAP?	Yes No
8.	Do you get short of breath on exertion? If yes, how far can you walk?	Yes No
9.	Have you had Hepatitis /liver disease / jaundice/ kidney disease?	Yes No
10.	Have you had or are you being treated for heart problems including Chest pain / angina or palpitations?	Yes No
11.	Have you ever had heart surgery, including pacemaker / implantable defibrillator / stents / valve replacement / bypass surgery?	Yes No
12.	Do you suffer from Epilepsy / fits / blackouts ?	Yes No
13.	Have you had a Stroke ? If yes, what year?.....	Yes No
14.	Have you ever had persistent anaemia / bleeding or clotting disorder?	Yes No
15.	<i>Please indicate if you have any of the following by circling:</i> hearing aid prosthesis joint replacements dentures bridge	Yes No
16.	Do you have glaucoma?	Yes No
17.	Have you had surgery in the last 6 months? If yes, what type of surgery?	Yes No
18.	Could you be pregnant?	Yes No
19.	Do you suffer from Gastric Reflux (Heartburn)?	Yes No
20.	Do you have a Lap Band or Gastric Sleeve?	Yes No
21.	Do you have Arthritis?	Yes No
22.	Have you had Rheumatic Fever / jaw or neck stiffness?	Yes No
23.	Have you sought treatment for Mental Health Issues?	Yes No
24.	Are you immunocompromised or taken cortisone drugs in the last six months?	Yes No
25.	Do you smoke? If YES amountPer day	Yes No
26.	Do you drink alcohol? If YES amountPer day	Yes No
27.	Do you take any medication, vitamins or supplements? If YES please list in section below.	Yes No



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PATIENT NAME: _____
 RESIDENTIAL ADDRESS: _____

 POSTAL ADDRESS: _____
 PHONE: _____

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28.	Do you have any difficulties standing unaided?	Yes	No
29.	Can you lay flat unaided?	Yes	No
The following questions relate to Infection Control and Cognitive Conditions. If you are unaware of the condition, please tick Unknown. These will be reviewed by a Nurse prior to admission.			
30.	Have you had an overnight stay in a hospital or residential care facility outside of Tasmania in the last 12 months? If yes where?	Yes	No
31.	Have you travelled overseas within the last 6 weeks?	Yes	No
32.	Have you had an infection, or been in contact with someone who has had an infection in the last two weeks?	Yes	No
33.	Have you ever had, or have a Multi-Resistant Organism Infection - MRSA, CRE, VRE?	Yes <input type="checkbox"/> Unknown	No
34.	Do you have 2 or more first or second degree relatives with Creutzfeldt-Jakob disease (CJD)?	Yes <input type="checkbox"/> Unknown	No
35.	Have you ever been involved in a 'look-back' for cCJD, or received a 'medical in confidence letter' regarding your risk of cCJD?	Yes <input type="checkbox"/> Unknown	No
36.	Do you have an undiagnosed progressive neurological illness of less than 12 months duration?	Yes <input type="checkbox"/> Unknown	No
37.	Did you receive pituitary growth hormone for infertility or human growth hormone for short stature prior to 1986?	Yes <input type="checkbox"/> Unknown	No
38.	Did you have surgery on your brain or spinal cord that included a dura mater graft prior to 1990?	Yes <input type="checkbox"/> Unknown	No
39.	Do you have any memory problems?	Yes	No
40.	Do you have a responsible adult to accompany you from The Eye Hospital and remain with you overnight following discharge?	Yes	No

Please record details of all medication taken including and vitamins or supplements;

Name of Medication	Dosage

Question Number	If you answered yes to any questions please clarify