PATIENT SELF - REPORTED QUESTIONNAIRE

Name: _____ Date: _____

Date of Birth: _____ Sex: M ☐ F ☐ U ☐ Ht: _____ Wt: _____

Address: _____ Phone: _____

Email Address: _____ Skype Address: _____

Referring Practitioner: _____ General Practitioner: _____ Physiotherapist: _____

Medicare Card Number: _____ Expiry Date: _____ Reference No.: _____

Health Insurance Provider: _____ Policy Number: _____ Next of Kin: _____

Do you have any allergies to any medications? ☐ Yes ☐ No If yes, please list the medications and reactions you have below: _____

_____

To your knowledge, do you have or have you ever had any of the following:

Respiratory Problems	Yes	No
Recent cold, Bronchitis or Pneumonia	☐	☐
Asbestosis	☐	☐
History of Asthma or Wheezing	☐	☐
Sleep Apnoea/Excessive Snoring	☐	☐
Use CPAP	☐	☐
Shortness of breath with exertion or rest	☐	☐
Emphysema/COPD	☐	☐
Chronic Bronchitis	☐	☐
Chronic Cough or Lung Problems	☐	☐
Tuberculosis/year: _____	☐	☐
Other: _____	☐	☐

Haematologic Problems	Yes	No
History of Anaemia (low blood count)	☐	☐
Sickle-Cell Anaemia ☐ Trait ☐	☐	☐
History of Bleeding or Bruising	☐	☐
Blood Transfusion. Year: _____	☐	☐
Phlebitis ☐ Blood Clots ☐	☐	☐
Von Willebrand Disease	☐	☐
Other: _____	☐	☐

Psychological Problems	Yes	No
Anxiety ☐ Depression ☐	☐	☐
Panic Disorders	☐	☐
Anorexia ☐ Bulimia ☐	☐	☐
Post-Traumatic Stress	☐	☐
Alzheimer's ☐ Memory Loss ☐ Dementia ☐	☐	☐
Schizophrenia	☐	☐
Bipolar	☐	☐
Needle Phobia	☐	☐
Other: _____	☐	☐

Musculoskeletal Problems	Yes	No
Chronic Pain: Neck ☐ Back ☐	☐	☐
TMD / Jaw Problems	☐	☐
Scoliosis	☐	☐
Osteoporosis ☐ Osteopenia ☐	☐	☐
Arthritis:	☐	☐
Type: RA ☐ OA ☐ Gout ☐		
Location: _____		
Other: _____	☐	☐

Ear/Eye Problems	Yes	No
Hearing Impaired	☐	☐
Deaf	☐	☐
Use of Hearing Aids	☐	☐
Glaucoma	☐	☐
Macular Degeneration	☐	☐
Blindness	☐	☐
Visual Impairment	☐	☐
Contact Lenses ☐ Glasses ☐	☐	☐
Other: _____	☐	☐

Cardiovascular Problems	Yes	No
Irregular Heart Beat	☐	☐
Mitral Valve Prolapse	☐	☐
Heart Murmur	☐	☐
Rheumatic Fever	☐	☐
High Blood Pressure	☐	☐
Fast Heart Beat/Palpitations	☐	☐
Heart Attack Year: _____	☐	☐
High Cholesterol	☐	☐
Heart Failure	☐	☐
Chest Discomfort or Tightness	☐	☐
Problems with arteries in the neck	☐	☐
Poor circulation to legs & feet	☐	☐
Other: _____	☐	☐

Gastrointestinal Problems	Yes	No
Liver Disease/ Jaundice/ Hepatitis	☐	☐
Chronic Heartburn	☐	☐
GI Bleed/Ulcer	☐	☐
Hiatal Hernia	☐	☐
Reflux	☐	☐
Crohn's Disease	☐	☐
Diverticulitis	☐	☐
IBS ☐ Ulcerative Colitis ☐	☐	☐
Gastroparesis	☐	☐
Pancreatitis	☐	☐
Trouble Swallowing	☐	☐
Other: _____	☐	☐

Dental Problems	Yes	No
Caps ☐ Crowns ☐ Implants ☐	☐	☐
Dentures: Full ☐ Partial ☐	☐	☐
Veneers ☐ Bondings ☐	☐	☐
Braces ☐ Retainers ☐	☐	☐
Loose where: _____	☐	☐
Chipped where: _____	☐	☐
Other: _____	☐	☐

Skin Problems	Yes	No
Rashes ☐ Rosacea ☐	☐	☐
Open Wounds Where: _____	☐	☐
Eczema ☐ Psoriasis ☐	☐	☐
MRSA	☐	☐
Shingles	☐	☐
Other: _____	☐	☐

Infectious/Communicable Disease	Yes	No
HIV/AIDS	☐	☐
Hepatitis B	☐	☐
Hepatitis C	☐	☐
Other: _____	☐	☐

Neurologic Problems	Yes	No
Tremors ☐ Parkinson's ☐	☐	☐
Stroke ☐ TIA (Mini-Stroke) ☐ Year: _____	☐	☐
Multiple Sclerosis ☐ Polio ☐	☐	☐
Weakness or Paralysis	☐	☐
Head Injury Year: _____	☐	☐
Neuropathy	☐	☐
Epilepsy/Seizures Last: _____	☐	☐
Migraines	☐	☐
Vertigo ☐ Meniere's ☐	☐	☐
Restless Leg Syndrome	☐	☐
Other: _____	☐	☐

Endocrine Problems	Yes	No
Thyroid Disorder Hyper ☐ Hypo ☐	☐	☐
Parathyroid Disorder	☐	☐
Diabetes	☐	☐
Adrenal Disorder ☐ Pituitary ☐	☐	☐
Other: _____	☐	☐

Urology Problems	Yes	No
Kidney Stones	☐	☐
Enlarged Prostate	☐	☐
Dialysis Peritoneal ☐ Haemo ☐	☐	☐
Stress Incontinence	☐	☐
Urinary Tract Infections	☐	☐
Interstitial Cystitis	☐	☐
Urinary Frequency	☐	☐
Other: _____	☐	☐

Developmental Problems	Yes	No
Intellectual Impairment	☐	☐
Learning Disabilities	☐	☐
Autism	☐	☐
ADHD	☐	☐
Other: _____	☐	☐

Other Problems	Yes	No
Cancer Where: _____	☐	☐
Other: _____	☐	☐

Women Only	Unsure	Yes	No
Are you pregnant?	☐	☐	☐
Are you breastfeeding?		☐	☐
Are you menopausal?	☐	☐	☐

Please Note: This form is PDF Fillable and can be completed electronically. Please fill out the form and then save with your name in the file name and email directly back to reception@brisbanehipclinic.com.au

Please list all previous surgeries or procedures which required anaesthesia and dates these where performed:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Have you had any problems with anaesthesia in the past? ☐ Yes ☐ No

If yes, please explain: _____

Have any of your relatives (parent, grandparents, siblings) had a problem with anaesthesia in the past? ☐ Yes ☐ No

If yes, please explain: _____

Do you have a religious or moral objection to medically recommended blood transfusions? ☐ Yes ☐ No

If yes, please explain: _____

Advanced Health Directive

Do you have an Advanced Directive (Living Will)? ☐ Yes ☐ No
Are you an organ donor? ☐ Yes ☐ No
Do you have a medical Power of Attorney? ☐ Yes ☐ No
If yes, who/relationship: _____

Pain Screening

1. Do you have a chronic problem with pain? ☐ Yes ☐ No
   If yes, where is your pain located? _____
2. Rate the severity of your pain: _____
   (0 = no pain, 10 = severe pain)

Nutritional Screening

Are you on any special diet? ☐ Yes ☐ No - ☐ Diabetic ☐ Renal ☐ Cardiac ☐ Other _____
Have you had any unintentional weight loss of more than 5kg over the past 3 months? ☐ Yes ☐ No
Have you been eating poorly because of a decreased appetite? ☐ Yes ☐ No
Are you vegetarian? ☐ Yes ☐ No Are you on a Keto diet? ☐ Yes ☐ No

Activity Screening

How many times a week, do you usually do 20 minutes or more of vigorous physical activity that makes you sweat or puff and pant? (e.g. jogging, heavy lifting, digging, aerobics, or fast cycling). ☐ > 3 times/week ☐ 1-2 times/week ☐ None

How many times a week, do you do 30 minutes or more of moderate physical activity or walking that increases your heart rate or makes you breath harder than normal? (e.g. mowing the lawn, carrying light loads, cycling at a regular pace, playing doubles tennis)
☐ > 5 times/week ☐ 3-4 times/week ☐ 1-2 times/week

Substance Screening

Have you ever smoked? ☐ Yes ☐ No
Do you currently smoke? ☐ Yes ☐ No
What do you smoke?
- Cigarettes ☐ Yes ☐ No
- Vaping/E-Cigarettes ☐ Yes ☐ No
- Cigars ☐ Yes ☐ No
- Marijuana ☐ Yes ☐ No
- Other _____ ☐ Yes ☐ No

If yes, how much/day? _____
Total number of years smoked? _____
When did you quit smoking? _____

Do you drink alcohol? ☐ Yes ☐ No
If yes, how many standard drinks / day? _____

Are you a recovering alcoholic? ☐ Yes ☐ No
If yes, how long? _____

Do you use recreational or IV drugs? ☐ Yes ☐ No
If yes, type, duration and frequency: _____

Do you drink caffeinated beverages? ☐ Yes ☐ No
If yes, how many / day? _____

Current Medication List

Please include insulin, oxygen, inhalers and any over-the-counter medications including aspirin, vitamins, herbs, minerals and supplements

Medication	Dose	Freq	Purpose	Breakfast	Lunch	Dinner	Bed
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐

Have you had any blood tests performed in the last 6 months? ☐ Yes ☐ No If yes, which pathology company? _____
Please list any specific concerns or questions you wish to discuss with your anaesthetist: _____

_____

_____

Are you happy for a copy of all reports and evaluations performed by Recovery Medical to be provided to your referring doctor, surgeon, anaesthetist and hospital?
☐ Yes ☐ No

Patient signature / name: _____ Date: _____

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