ST JOHN OF GOD
Frankston Rehabilitation Hospital

PATIENT HEALTH QUESTIONNAIRE

U.R. Number .....
Surname .....
Given Names .....
Date of Birth ...../...../..... Sex .....
Use Label If Available or BLOCK LETTERS

Date Form Completed .....

Form Completed By ☐ Patient ☐ Parent/Guardian ☐ Next of Kin ☐ Carer ☐ Other .....

If you are the primary carer do you plan to be present throughout the hospital admission? ☐ Yes ☐ No

Do you have any specific religious, cultural beliefs or customs that we need to consider when we are planning your care? .....

Do you have any concerns about this admission? .....

.....

Do you have difficulties or pain that could affect the way we care for you? .....

.....

Do you have a legally appointed decision maker to act on your behalf? ☐ Yes ☐ No

Name .....

Do you have an Advance Care Plan? (a statement of preferences about health and personal care and health outcomes)

☐ Yes (If yes, please provide a copy) ☐ No

Height (cm) ..... **Weight (kg)** ..... BMI (Hospital Use Only)

ALLERGIES / ADVERSE REACTIONS Please complete questions below, if yes please provide details and dates

Have you ever had an allergy / adverse reaction to any product?	☐ Yes ☐ No	☐ Medications ☐ Tape ☐ Lotions ☐ Latex/rubber ☐ Food ☐ Other .....
Have you or a blood relative ever had an adverse reaction to an anaesthetic?	☐ Yes ☐ No	
Have you ever had post surgical confusion/ delirium?	☐ Yes ☐ No	

Do you take any MEDICATIONS? ☐ Yes, complete details below (please add list if insufficient space) ☐ NO, go to next section

Include all prescribed and over the counter medications that you currently take in any form (tablets, liquid, drops, ointment, puffers, patches, injections, herbal preparations).

Please make arrangements to bring medication in its original packaging as Webster packs may not be able to be used in hospital

Medication name and strength	Amount	Frequency	Medication name and strength	Amount	Frequency

Has your Doctor advised you to cease any medication prior to your admission to hospital? ☐ Yes ☐ No

Name of Medication/s to be ceased .....

Date/s to be ceased .....

Have you had PREVIOUS SURGERY? ☐ Yes, complete details below (add list if insufficient space) ☐ No, go to next section

Operation	Year	Operation	Year

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INFECTION RISK ASSESSMENT Please complete questions below, if yes please provide details and dates

Have you been admitted to or worked in any hospital or residential facility in the last 12 months?	☐ Yes ☐ No	Name Date of last attendance/shift
Have you ever been diagnosed with a multi-resistant infection? e.g. MRSA, VRE, CRE	☐ Yes ☐ No	
Have you or any blood relative been diagnosed with Creutzfeldt Jakob Disease (CJD) or do you have a medical in confidence letter regarding this disease?	☐ Yes ☐ No	

PREVIOUS TRANSFUSIONS Please complete questions below, if yes please provide details and dates

• Have you ever had a blood transfusion?	☐ Yes ☐ No	Date/s:
• Have you ever had an iron infusion?	☐ Yes ☐ No	Date/s:
• Have you ever had a reaction to a blood transfusion or iron infusion?	☐ Yes ☐ No	Describe:

MEDICAL HISTORY (Please provide relevant details and year of diagnosis/event)

Have you ever had any problems with your heart or your circulation? ☐ Yes, complete details below ☐ No, go to next section

• Heart condition	☐ Yes	
• Blood pressure problems	☐ Yes	
• Heart irregularities e.g. atrial fibrillation or murmur	☐ Yes	
• Heart surgery	☐ Yes	Details ☐ Heart valve replacement ☐ Pacemaker ☐ Implanted defibrillator Brand Cardiologist Date checked
• A blood clot in your lungs or legs	☐ Yes	Year
• Vascular disease e.g. carotid, peripheral vascular disease	☐ Yes	

Have you ever had any problems with your breathing or lungs? ☐ Yes, complete details below ☐ No, go to next section

• Sleep apnoea, disturbed sleep, snoring	☐ Yes	Do you use a CPAP machine? ☐ Yes If yes please bring to hospital (overnight stay only)
• Lung condition or disease e.g. asthma, pneumonia, bronchitis	☐ Yes	
• Shortness of breath with normal daily activities	☐ Yes	
• Require home oxygen	☐ Yes	Supplier:

Have you ever had any problems with your stomach, bladder or bowel? ☐ Yes, complete details below ☐ No, go to next section

• Liver disease, hepatitis, jaundice, cirrhosis	☐ Yes	
• Hiatus hernia, gastrointestinal ulcers, reflux	☐ Yes	
• Bowel problems, a Stoma or disease e.g. Crohn's Disease, incontinence, constipation	☐ Yes	

NO WRITING IN MARGINS

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MEDICAL HISTORY Continued (please provide relevant details and year of diagnosis/event)

• Kidney disease or impairment, dialysis (specify type), recurrent urinary tract infections or incontinence	☐ Yes	

Do you have or have you ever had Diabetes? ☐ Yes, complete details below ☐ No, go to next section

☐ Type 1 ☐ Type 2 ☐ Other ☐ Insulin ☐ Diet ☐ Tablets ☐ Insulin Pump

Have you ever had any neurological conditions? ☐ Yes, complete details below ☐ No, go to next section

• Neuromuscular e.g. Parkinson's Disease	☐ Yes	
• Stroke, mini stroke (TIA), fainting	☐ Yes	Date:
• Limb paralysis or weakness	☐ Yes	
• Swallowing problems	☐ Yes	
• Epilepsy, fits, blackouts, dizziness	☐ Yes	Approximate date of last event:
• Difficulties with your memory, problem solving or dementia	☐ Yes	
• Intellectual impairment or behavioural conditions	☐ Yes	

Have you ever had any musculoskeletal or skin conditions? ☐ Yes, complete details below ☐ No, go to next section

• Problems with your back, neck or jaw	☐ Yes	
• Arthritis	☐ Yes	
• A wound, ulcer, pressure sore, skin tear, fragile skin or other skin condition	☐ Yes	Location:

Have you ever had any blood conditions? ☐ Yes, complete details below ☐ No, go to next section

• Blood or bleeding disorders	☐ Yes	

Have you ever had a diagnosis of cancer? ☐ Yes, complete details below ☐ No, go to next section

Date of diagnosis Type Site

Are you undergoing cancer treatment currently? ☐ Yes ☐ No

Treatment type Date of last treatment

Do you have a disability or any problems with your mobility? ☐ Yes complete details below ☐ No, go to next section

• A physical disability	☐ Yes	
• A fall in the last 12 months or unsteady on your feet	☐ Yes	
• Require assistance with your daily activities e.g. showering, getting out of bed	☐ Yes	
• Require assistance with mobility	☐ Yes	☐ Wheelchair ☐ Hoist transfer ☐ Walking aids ☐ Other (provide details) No. of people to assist

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MEDICAL HISTORY Continued (please provide relevant details and year of diagnosis/event)

Do you have a mental health problem or diagnosis? ☐ Yes, complete details below ☐ No, go to next section

Anxiety disorders, affective disorders (depression), psychotic illness	☐ Yes	

Other Conditions and lifestyle choices. Please complete questions below, if yes please provide details and dates

Do you use any visual or hearing aids or prosthetic devices?	☐ Yes ☐ No	☐ Hearing aids ☐ Contact lens ☐ Glasses ☐ Prosthetic devices _____ ☐ Other _____
Do you have any caps, implants, crowns, loose teeth or dentures?	☐ Yes ☐ No	
Are you or could you be pregnant? (female only)	☐ Yes ☐ No	Due date
Have you had unexplained weight loss without trying over the past 3 months?	☐ Yes ☐ No	
Do you, or have you, ever smoked?	☐ Yes ☐ No	How many per day? When stopped?
Do you drink alcohol?	☐ Yes ☐ No	How many standard drinks per day?
Do you use illicit drugs?	☐ Yes ☐ No	What type? How often?
Do you have any other serious health problems not covered above?	☐ Yes ☐ No	

PLANNING FOR YOUR DISCHARGE

Do you have a responsible adult to collect you from hospital and to remain with you for 24 hours post surgery? (surgical patients only)	☐ Yes ☐ No	It is required that you have a responsible adult collect you from hospital and remain with you for 24 hours post anaesthetic. Your nursing caregiver will ask for contact details at the time of your admission.
Have your needs been assessed by an Aged Care Assessment Service (ACAT/S)?	☐ Yes ☐ No	Date of Assessment Outcome
Do you attend a day centre or receive assistance from a community service for meals, home help or personal care?	☐ Yes ☐ No	(please advise the service of your intended absence)
Is there any other information that would help us to support you for discharge?	☐ Yes ☐ No	

HOSPITAL USE ONLY

I have reviewed and discussed the details provided with the patient while planning their care.

Pre-admission Caregiver:

Name _____ Designation _____ Date _____ Signature _____

Admitting Caregiver:

Name _____ Designation _____ Date _____ Signature _____

NO WRITING IN MARGINS