

Place ID Label Here

PATIENT HEALTH QUESTIONNAIRE

To be completed by Patient or Carer and forwarded to admit@esphospital.com two weeks prior to admissionPlease *PRINT* clearly. Your responses are valuable in planning your admission and caring for you during your stay.

ADMISSION DETAILS

Please specify the reason for your admission _____

What is your expected outcome / result of your admission / surgery? _____

Is this admission due to a past or present injury? (If yes please provide further information below) ☐ Yes ☐ No

Cause of Injury: _____

Have you used GLP-1 injections within the past 5 weeks (such as Ozempic, Wegovy, Mounjaro, Trulicity, Saxenda or Victoza)? ☐ Yes ☐ No

If yes, Name of GLP1 _____ Date of last injection _____ dose _____

If you have used GLP1 medications within the last 5 weeks and completing this form within 24 hours of your planned procedure, please contact the hospital on 9001 2000 or your specialist's rooms for further advice.

Have you been instructed to cease any medication? (If yes please provide further information below) ☐ Yes ☐ No

Name of Medication/s: _____

Date last taken ____ / ____ / ____ or ☐ still taking**Have you taken any steroids or cortisone tablets/injections in the last 6 months?** ☐ Yes ☐ No(If yes please provide further information) Date last taken ____ / ____ / ____ or ☐ still taking**Are you taking any other prescription or non-prescription medications?** ☐ Yes ☐ No**List all medications you are currently taking (including prescription, over-the-counter, and herbal)**

If you need more space please attach a current list of all medications and bring this with you on admission,

• Medication: _____ for Treatment of _____
Frequency _____ Dose _____• Medication: _____ for Treatment of _____
Frequency _____ Dose _____• Medication: _____ for Treatment of _____
Frequency _____ Dose _____• Medication: _____ for Treatment of _____
Frequency _____ Dose _____• Medication: _____ for Treatment of _____
Frequency _____ Dose _____• Medication: _____ for Treatment of _____
Frequency _____ Dose _____• Medication: _____ for Treatment of _____
Frequency _____ Dose _____**Please bring all medications you are currently taking with you on admission in the original packaging including herbal medicines.**

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GENERAL MEDICAL CONDITION

Weight:	Height:	BMI:
Diabetes	☐ Yes ☐ No	If yes, what type? ☐ Type 1 ☐ Type 2 Managed by: ☐ Insulin injection ☐ Tablet ☐ Diet What medication do you take?
Cancer (current or prior)	☐ Yes ☐ No	Site: _____ Date: _____
Stroke	☐ Yes ☐ No	Date: _____ Residual problems: _____
High Blood Pressure	☐ Yes ☐ No	
Cardiac history Have you ever seen a cardiologist or had heart problems?	☐ Yes ☐ No	If yes, provide details: _____
Pacemaker	☐ Yes ☐ No	Make: _____ Model: _____ Last checked: / /
Prosthetic heart valve	☐ Yes ☐ No	Type: _____
Tendency to bleed / bloodclots / DVTs / bruise easily	☐ Yes ☐ No	If yes, provide details: _____
Asthma / Bronchitis / Sleep Apnea / Breathlessness / Pneumonia etc	☐ Yes ☐ No	Please specify: _____
Liver disease / hepatitis (Specify type A, B, C)	☐ Yes ☐ No	If yes, provide details: _____
Kidney / bladder problems	☐ Yes ☐ No	If yes, provide details: _____
Hiatus hernia / gastrointestinal ulcers / bowel disorder	☐ Yes ☐ No	If yes, provide details: _____
Thyroid problems	☐ Yes ☐ No	If yes, provide details: _____
Epilepsy / fits / febrile convulsions	☐ Yes ☐ No	If yes, provide details: _____
Migraines	☐ Yes ☐ No	
Eye disease	☐ Yes ☐ No	
History of pressure injuries	☐ Yes ☐ No	
Female patients could you be pregnant?	☐ Yes ☐ No	Number of weeks: _____
Do you have any other medical conditions not listed here?	☐ Yes ☐ No	details: _____

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PREVIOUS OPERATIONS / PROCEDURES / ANAESTHETIC DETAILS

Have you had previous operations, please list dates and operations performed: ☐ Yes ☐ No

Operation:	Date:	Operation:	Date:
Operation:	Date:	Operation:	Date:
Operation:	Date:	Operation:	Date:

Have you or anyone in your immediate family ever had a severe reaction to an anesthetic? e.g. malignant hyperthermia ☐ Yes ☐ No Details of reaction:

Have you ever had a blood transfusion? ☐ Yes ☐ No Details of reaction:

PROSTHESIS / AIDS / OTHER

DETAILS

Glasses /Contact Lenses ☐ Yes ☐ No

Body Piercing ☐ Yes ☐ No

Hearing aid or other hearing appliance ☐ Yes ☐ No

Dentures /Caps /Crowns /Loose Teeth /wires ☐ Yes ☐ No

Artificial joints or limbs /Metalware in body ☐ Yes ☐ No

LIFESTYLE

DETAILS

Have you ever smoked? ☐ Yes ☐ No Daily amount: or date ceased:

Do you drink alcohol? ☐ Yes ☐ No Daily amount:

Do you use recreational drugs? ☐ Yes ☐ No Type: Daily amount: How Often:

Do you exercise? ☐ Yes ☐ No How Often:

DIET

DETAILS

Do you require a special diet? ☐ Yes ☐ No Type of Diet:

COMMUNICATION

DETAILS

Do you require an interpreter? ☐ Yes ☐ No Language spoken at home:

Do you have someone to interpret for you? ☐ Yes ☐ No Name of Person / Relation:

Are you hearing or vision impaired? ☐ Yes ☐ No Details:

MOBILITY AND FALLS RISK

DETAILS

Have you a fear of falling or have fallen within the last 6 months? ☐ Yes ☐ No

Do you use mobility aids? ☐ Yes ☐ No Type:

Can you walk up one flight of stairs? ☐ Yes ☐ No

Have you experienced fainting or dizziness in the last 3 months? ☐ Yes ☐ No

Do you use a falls alarm or sensor at home? ☐ Yes ☐ No

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ALLERGIES

Food allergies

☐ Yes ☐ No

Food:	Reaction:
Food:	Reaction:
Food:	Reaction:
Food:	Reaction:

Are any of the above food allergies life-threatening (e.g. anaphylaxis)?

☐ Yes ☐ No

Medication allergies

☐ Yes ☐ No

Medication:	Reaction:
Medication:	Reaction:
Medication:	Reaction:
Medication:	Reaction:

Are any of the above medication allergies life-threatening (e.g. anaphylaxis)?

☐ Yes ☐ No

Other allergies (Latex / sticky plasters etc):

☐ Yes ☐ No

Are any of the above Other allergies life-threatening (e.g. anaphylaxis)?

☐ Yes ☐ No

PSYCHOLOGICAL / MENTAL HEALTH

Do you experience:	What are your triggers?	What controls work for you?
Anxiety ☐ Yes ☐ No		
Phobias ☐ Yes ☐ No		
Mood Disorders ☐ Yes ☐ No		
Eating Disorders ☐ Yes ☐ No		
Other psychosis ☐ Yes ☐ No		

Are you currently supported by a mental health clinician?

☐ Yes ☐ No

Name:

Service:

Contact number:

If your procedure is cosmetic in nature, have you ever had a physiological consultation related to cosmetic surgery?

☐ N/A ☐ Yes ☐ No

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INFECTION RISK

Have you travelled to a country with a health alert in the last 7 days? ☐ Yes ☐ No

Do you have a fever and/or respiratory symptoms eg. cough, sore throat, runny nose? ☐ Yes ☐ No

Have you had recent contact with patient/s diagnosed with Acute Respiratory Infections or Acute Respiratory Illness in the last 7 days (Seasonal or Pandemic)? eg. COVID-19, SARs/ H5N1 Influenza, either overseas or in Australia, within 7 days of onset of symptoms. ☐ Yes ☐ No

Have you travelled to areas of high prevalence for Acute Respiratory Infections or Acute Respiratory Illness in the last 7 days (Seasonal or Pandemic)? e.g. SARs/H5N1 Influenza, either overseas or in Australia, within 7 days of onset of symptoms. ☐ Yes ☐ No

Have you ever had a Multi-Resistant Organism such as MRSA/Golden Staph, VRE, ESBL or Clostridium difficile? ☐ Yes ☐ No

Do you have any chronic non-healed wounds or breaks on your skin? ☐ Yes ☐ No

Do you have any other conditions or infections? ☐ Yes ☐ No

Have you had vomiting and diarrhoea in the last 48 hrs? ☐ Yes ☐ No

QUESTIONS RELATING TO CREUTZFELDT JAKOB DISEASE

Have you had surgery on the brain or spinal cord that may have included a dura mater graft, prior to 1990? ☐ Yes ☐ No

Have you had two or more first degree relatives diagnosed with Creutzfeldt-Jakob Disease (CJD) or other prion disease, where a genetic cause has not been excluded? ☐ Yes ☐ No

Have you suffered from a recent progressive dementia illness (physical or mental), the cause of which has not been diagnosed? ☐ Yes ☐ No

Have you received human pituitary hormones for infertility or human growth hormone for short stature, prior to 1986? ☐ Yes ☐ No

Have you been involved in a "Look Back" study for cCJD or are in the possession of a "Medical in Confidence Letter" regarding risk of cCJD? ☐ Yes ☐ No

DISCHARGE PLANNING

This information is necessary in order to help you plan a safe return to home after discharge. ALL patients to complete

Are you over 80 years of age? ☐ Yes ☐ No

Do you live alone? ☐ Yes ☐ No

Do you have stairs at home? ☐ Yes ☐ No

If yes, do you have handrails? ☐ Yes ☐ No

I have someone to look after me after discharge. ☐ Yes ☐ No

Name of person and Relationship:

Are you solely responsible for the care of another person at home? ☐ Yes ☐ No

Do you currently receive community support services? ☐ Yes ☐ No

Do you require assistance with any aspect of daily living? ☐ Yes ☐ No

Where do you plan to go after discharge?

☐ Home ☐ Rehab ☐ Carer ☐ Other

How do you plan to get there?

I have organised an escort to accompany me: ☐ Yes ☐ No

Name:

Do you have any concerns about how you will manage at home after discharge? ☐ Yes ☐ No

Name of person completing form:

Relationship:

Date: