Health Questionnaire

To provide you with the best possible treatment, please complete the following.

SUNSHINE COAST NEUROSURGERY

Patient Details

First Name: Surname:

DOB: DD / MM / YYYY What is your height? cm What is your weight? kg

Do you smoke? ☐ Yes ☐ No If Yes, how many: /day Do you drink alcohol? ☐ Yes ☐ No If Yes, how much: /day

Treatment Area

☐ Left ☐ Right ☐ Both

☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand

☐ Hip ☐ Knee ☐ Ankle/Foot ☐ Neck/Back/Pelvis

Medical History

Do you have or have you ever had the following conditions? Please answer every question and tick where appropriate.

	Yes	No		Yes	No
Asthma, emphysema, shortness of breath or other lung problems	☐	☐	Kidney problems	☐	☐
Diabetes. If yes, controlled by: ☐ Diet ☐ Tablets ☐ Insulin	☐	☐	Hepatitis/liver problems	☐	☐
Heart attack, palpitations, angina	☐	☐	Varicose veins	☐	☐
Heart murmur	☐	☐	Deep vein thrombosis (blood clots in the leg)	☐	☐
High blood pressure	☐	☐	Pulmonary embolus (blood clots in the lungs)	☐	☐
Pacemaker or other heart implants	☐	☐	Previous blood transfusions	☐	☐
Elevated cholesterol/triglycerides	☐	☐	Do you take any blood thinning medication such as Aspirin, Warfarin, Plavix, or anti-inflammatories?	☐	☐
Stroke (CVA)	☐	☐	Depression	☐	☐
Epilepsy/fits/faints/funny turns	☐	☐	Neck or back injuries/problems	☐	☐
Stomach problems, gastric ulcer, indigestion or reflux	☐	☐	Problems with anaesthetics, e.g. vomiting	☐	☐
Bleeding or clotting disorder Please specify:	☐	☐	Do you have any current wound or skin breaks?	☐	☐
HIV/AIDS	☐	☐	Have you ever had an MRSA (golden staph) infection?	☐	☐
Thyroid problems	☐	☐	Have you ever had a VRE infection?	☐	☐
Cancer Please specify:	☐	☐	Other:	☐	☐

Current medications: *(including Herbal and/or Natural Therapies)*

Allergies to medications/metals/other:

Previous surgery: *(including dates if possible)*

Any complications with previous surgery:

Any problems/complications with previous anaesthetics:

Which of the following causes you to become short of breath: ☐ Exercise ☐ Climbing stairs ☐ Walking on the flat ☐ At rest ☐ Unsure

Do You Know Your Blood Group: ☐ Yes ☐ No If Yes: ☐ A ☐ B ☐ AB ☐ O ☐ Positive Negative

I certify that the information given above is true and accurate to the best of my knowledge and ability.

Signature of Patient/Guardian/POA: Date: DD / MM / 20YY