ST VINCENT'S HOSPITAL MELBOURNE
A FACILITY OF ST VINCENT'S HEALTH AUSTRALIA

ST. VINCENT'S MELBOURNE

HEALTH QUESTIONNAIRE

Lithotripsy Service

UR No.: _____
Surname: _____
Given Name: _____
D.O.B.: _____
Please fill in if no Patient Label available

Please answer these questions carefully.

Medical History

Have you ever had any of the following?

Height _____ cm
Weight _____ kg

	No	Yes	
High blood pressure	❑	○	
Chest pain or angina	❑	○	⇨ How often?
Heart attack	❑	○	⇨ When?
Other Heart Disease or heart murmur	❑	○	⇨ What type?
Stroke	❑	○	⇨ Remaining disability?
Asthma	❑	○	⇨ Is it under control?
Chronic cough or chronic bronchitis	❑	○	⇨ Is it productive?
Any other lung or chest disease	❑	○	⇨ What type?

	No	Yes		No	Yes
Diabetes	❑	○	⇨ Do you take Insulin?	❑	○
			Do you take tablets?	❑	○
Hepatitis	❑	○	⇨ When?		
Fits or Epilepsy	❑	○	⇨ Last Episode?		
Kidney condition	❑	○	⇨ What type?		
Blood clots in legs or lungs	❑	○	⇨ When?		
Heartburn/Indigestion/Hiatus hernia	❑	○	⇨		

	No	Yes	
Do you have a permanent pacemaker?	❑	○	
Have you ever been diagnosed with sleep apnoea?	❑	○	
Do you get short of breath if you climb one flight of stairs (8 – 10 steps)?	❑	○	
Do you have any other health condition or serious illness?	❑	○	⇨What are they?

Have you ever had:

	No	Yes	
Any operations?	❑	○	⇨ What are they? Any problems?
Blood transfusions?	❑	○	⇨ Any reactions?
Any intensive care admissions?	❑	○	⇨

Have you or your family had:

	No	Yes		
Serious bleeding/clotting problems?	❑	○	⇨	Please describe
Serious reactions to general anaesthesia?	❑	○	⇨	What type?
Medical problems which run in the family eg muscular dystrophy, thalassaemia?	❑	○	⇨	What type?
Females: Are you pregnant?	❑	○	⇨	Due date?

HEALTH QUESTIONNAIRE - ST. VINCENT'S MELBOURNE

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ST. VINCENT'S MELBOURNE

HEALTH QUESTIONNAIRE

UR No.: _____
Surname: _____
Given Name: _____
D.O.B.: _____
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Medications, adverse reactions and substance use:

	No	Yes	
Do you have any allergies or have you had any reactions to any medications?	❑	❑ ⇨	Please describe.

	No	Yes	
Do you take aspirin or blood thinners regularly?	❑	❍	
Have you ever taken cortisone type medication?	❑	❑ ⇨	When?
Do you smoke?	❑	❍ ⇨	How many?
Do you drink alcohol?	❑	❍ ⇨	How much?
Do you use any other substances? (eg heroin, cocaine, marijuana)	❑	❍ ⇨	Which ones?
Do you take any vitamin or herbal medication?	❑	❍ ⇨	Please list below
Do you take any regular medication?	❑	❍ ⇨	Please list below

Name of medication	Dose(mg)	When? (morning, evening, etc.)

Discharge planning information

	No	Yes
Day case patients must have an adult to accompany them home		
Can you arrange a friend or family member to collect you and stay with you for 24 hours after the procedure?	❑	❍
Will you have problems looking after yourself after your hospital stay?	❑	❍
Do you take care of others at home?	❑	❍
Are you homeless / no fixed place of address?	❑	❍
Do you live in a rooming house, private hotel, crisis accomodation or hostel?	❑	❍
Do you use community services? eg Home help, meals-on-wheels, etc.	❑	❍
Do you require an interpreter?	❑	❍
Are you currently under mental health care?	❑	❍

Weight (kg):

❍ Invasive ❍ Invasive with blood loss

Medicare Card Number:

MI <20 ❍ BMI >35 ❍ BMI >40

Blood pressure ____ \ ____

Card Expiry:

Signature: _____ Print Name: _____ Date: _____