Haematology QUEENSLAND

PATIENT QUESTIONNAIRE and MEDICAL INFORMATION SHEET

Date ....

INTRODUCTION...

This information sheet is intended to help gather information about your medical history, to assist the consultation.

Any responses that you are not able to complete, for whatever reason (e.g., uncertainty, not enough space provided, confidentiality) can be discussed during the consultation.

GENERAL INFORMATION...

Full Name: ....

Date of Birth: .... Place of Birth: ....

Marital Status: ○ Married / Defacto ○ Single ○ Widowed ○ Separated / Divorced

Next of Kin: ....

Dependants / Children: ....

Referring Doctor: ....

MAIN CONCERN / REASON for CONSULTATION...

....

....

ALLERGIES... ○ NO ○ YES please detail below

Allergic to:	What happens?

WEIGHT... Current weight .... kg / Ideal weight .... kg

CURRENT MEDICATIONS... O NO O YES please detail below

Medical Condition	Drug	Dose	Frequency

Do you regularly take any over the counter medicines, vitamins, complimentary or herbal medicines?

O NO O YES please detail below

....

SMOKER... O Never O Yes O Previously - stopped: ....

How much do / did you smoke? .... per day for .... years

ALCOHOL INTAKE... O Never O Yes O Previously - stopped: ....

How much do / did you drink? .... per day for .... years

DIET...

Have you ever been diagnosed with...			Year
Iron deficiency	O NO	O YES	
Vitamin B12 deficiency (pernicious anaemia)	O NO	O YES	
Coeliac disease	O NO	O YES	
Vitamin D deficiency	O NO	O YES	

Does your diet include the following...			
Dairy	O Milk	O Yogurt	O Cheese
Cereals	O Grains	O Bread	O Breakfast Cereals
Meat	O Red Meat	O Chicken	O Fish
Vegetables	O Potato	O Green Leafy Vegetables	O Other ....
Fruit			

FOOD ALLERGIES... O NO O YES please detail below

....

MEDICAL HISTORY...

Have you been hospitalised during the past year? O NO O YES please detail below

....

....

Have you been treated or hospitalised for any of the following:

Condition			Comments
Asthma	O NO	O YES	
Eczema	O NO	O YES	
Rash	O NO	O YES	
Chest Infections	O NO	O YES	
Recent Infections	O NO	O YES	
Migraine / Severe Headache	O NO	O YES	
Seizures / Epilepsy	O NO	O YES	
Diabetes	O NO	O YES	Year .... O Insulin Injections O Tablets
Urinary Tract Infection	O NO	O YES	
Diverticulitis	O NO	O YES	
Heart Problems	O NO	O YES	
High Blood Pressure	O NO	O YES	
Arrhythmia / Abnormal Heart Beat	O NO	O YES	
Heart Attack / Myocardial Infarction	O NO	O YES	
Angina	O NO	O YES	
Bleeding / Bruising	O NO	O YES	
Deep Venous Thrombosis (clot)	O NO	O YES	Site .... Warfarin : O No / O Yes
Pulmonary Embolism (lung clot)	O NO	O YES	Details?
Shingles / Chicken Pox	O NO	O YES	
Cold Sores / Whitlow	O NO	O YES	
Hepatitis	O NO	O YES	
Learning Difficulty	O NO	O YES	
Physical Disability	O NO	O YES	
Depression	O NO	O YES	
Other Emotional Concerns	O NO	O YES	
Other (Details?)			

SURGICAL HISTORY... (previous operations)

Year	Reason

Have you ever had...

			Details
Joint Replacement	O NO	O YES	
Broken Bone	O NO	O YES	
Major Head Injury	O NO	O YES	
Dental Extraction	O NO	O YES	
When was your last dental examination?			
Do you wear dentures	O NO	O YES	

IMMUNISATIONS... Have you been immunised for the following?

Influenza (this year)	O NO	O YES	O UNSURE	O Previous years eg since ....
Whooping cough (Pertussis)	O NO	O YES	O UNSURE	O Grandparents
Pneumococcus (Pneumovax)	O NO	O YES	O UNSURE	O >65yrs, no spleen
Haemophilus (Hib)	O NO	O YES	O UNSURE	O Lung disease, low immunity
Chickenpox / Varicella (Zostervax)	O NO	O YES	O UNSURE	O Recurrent shingles >50yrs
Hepatitis B and/or A	O NO	O YES	O UNSURE	
Papilloma Virus HPV (Gardisil)	O NO	O YES	O UNSURE	
Diphtheria/Pertussis/Tetanus	O NO	O YES	O UNSURE	
Measles, Mumps, Rubella (MMR)	O NO	O YES	O UNSURE	
Meningococcal	O NO	O YES	O UNSURE	
Tuberculosis (BCG)	O NO	O YES	O UNSURE	
Other (eg travel)				

FAMILY HISTORY...

Mother: .... ○ Alive / ○ Died at .... years

Father: .... ○ Alive / ○ Died at .... years

Children: .... years ....

.... years ....

.... years ....

Brothers / Sisters: .... years ....

.... years ....

.... years ....

Is there any family history of: ○ leukaemia ○ lymphoma ○ bleeding ○ thrombosis

○ cancer ....

Other relevant information about family members / illnesses:

....

....

....

COMPLETED BY...

NAME (printed): ....

SIGNATURE: .... Date: .... / .... / ....

Thank-you for your time. When you have your consultation, please let me know if you have any questions about this form.