Peninsula Health

PRE ADMISSION SERVICE QUESTIONNAIRE

Patient to Complete

UR NUMBER ....

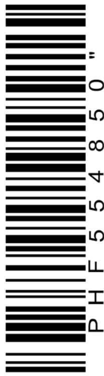
SURNAME ....

GIVEN NAMES ....

DATE OF BIRTH ....

Please fill in if no Patient Label available

Rev.4/11/2022 Print Code:10562



PERSONAL DETAILS

Q1. Have you ever attended Peninsula Health before? NO ☐ YES ☐ Previous Name used ....

Q2. Are you a permanent resident of Australia? YES ☐ NO ☐ If no state Passport Number, visa type & expiry date ....

....

Title Mrs ☐ Ms ☐ Miss ☐ Mr ☐	Address:
Family Name:	Suburb: State:
First Name:	Postcode:
Gender: Pronouns:	Mobile Number:
Date of birth:	Home Number:
Country of birth:	Email:
Language Spoken:	Religion:
Do you need an interpreter? YES ☐ NO ☐	Special Needs:

Marital Status: Single ☐ Married ☐ Defacto / Partner ☐ Separated ☐ Widowed ☐

Patient Indigenous state: None ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐

Preferred Contact Person in case of emergency

First Name & Family Name:	Mobile Number:
Relationship to you:	Home Number:

Health Insurance Details

Medicare Number:	Medicare expiry:
Private Insurance Details: NO ☐ YES ☐	Insurance Company:
Health Fund Number:	Level of Cover:

Other Insurance Options (please bring your card each visit)

Health Care Card Number		Expiry:
Pension Card Number		Expiry:
DVA: Gold ☐ White ☐ Number		Expiry:
Visit related to: (please bring supporting documentation to each visit)	Workcover Claim Number:	TAC Claim Number:

GP Details

GP Name:	Phone Number:
Address:	
Suburb:	State: Postcode:
Date of last visit:	

From time to time we contact patients regarding our community activities, hospital developments and support. We respect privacy, so please tick if you do not wish to be contacted. If you do not mark this box you are agreeing to Peninsula Health Hospital contacting you in the future.

☐ **I DO NOT** *wish to be contacted by* ***Peninsula Health Hospital***

I confirm to the best of my knowledge this information provided is accurate and complete

NAME (PRINT): .... SIGNATURE: .... Date ....

Completed via phone / Verbal Consent received YES ☐ NO ☐

Staff member completing form via Phone .... Staff member Designation .... Date ....

PRE ADMISSION SERVICE QUESTIONNAIRE

MR/554850

Peninsula Health

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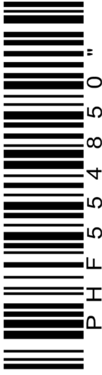

PLEASE COMPLETE FOLLOWING 4 PAGES OF THIS QUESTIONNAIRE ACCURATELY
Incomplete or unreturned forms will cause your surgery to be delayed.

HEIGHT: *(CM)*	**WEIGHT:** **(kg)**	**BMI:** (office use only)

MEDICATIONS
PLEASE OUTLINE ANY MEDICATIONS THAT YOU ARE CURRENTLY USING
List all medications including over the counter medications (including herbal remedies), pain killers, eye drops and puffers.

NAME OF MEDICATION *If you have a list of medications from your local doctor/pharmacy please attach*	**DOSE**	**TIME TAKEN DAILY**

REGULAR PHARMACY NAME		Phone Number	

ALLERGIES	**NO**	**YES**	**Please describe reaction**
Latex Allergy?			
Food?			
Medication Allergy? (such as Penicillin)			
Tapes?			
Other			

OPERATIONS Please list all previous operations in the spaces below

OPERATIONS	**YEAR**	**HOSPITAL**

04/11/2022 Print Code:10562 Page 2 of 5 LUW, Allanby & DMR e form

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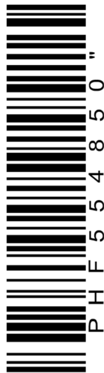

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING

DIABETES	NO	YES	
Are you Diabetic? Type 1 ☐ Type 2 ☐ Unsure ☐			How is your Diabetes treated? Insulin ☐ Tablets ☐ Diet ☐
Do you have an Endocrinologist / diabetes doctor? Name:			Contact number: Date of last visit:
Do you monitor your blood glucose levels?			How often: What are your usual blood glucose levels:

HEART	NO	YES	FURTHER DETAILS
High blood pressure			
Angina or chest pain,			
(a) How often do you get angina?			
(b) Do you get angina during activity or exercise?			
(c) Do you get angina when resting or at night?			
Heart attack			Date: ....
Palpitations or irregular heart beat			Specify
Insertion of heart valve, coronary stent or pacemaker (specify)			Date: ....
Rheumatic fever			
Heart Murmur			
Are you being treated by a Cardiologist / Heart Specialist			What is the Specialist's name / Phone No .... Last Visit: ....

LUNGS	NO	YES	FURTHER DETAILS
Are you being treated by a Lung / Respiratory Specialist What is the Specialist's name / Phone No			.... Last Visit: ....
Do you smoke			How many per day? ....
Are you an ex-smoker			When did you stop? ....
Asthma or shortness of breath			Specify
How many times per week do you use Ventolin?			Specify
Bronchitis or emphysema			Specify
Pneumonia or tuberculosis			Specify
Obstructive sleep apnoea as diagnosed by your doctor			Do you use CPAP? No ☐ Yes ☐
Have you had a sleep study?			When? Where?
Shortness of breath that prevents you from climbing one flight of stairs			
Home Oxygen therapy			

ANAESTHETICS	NO	YES	FURTHER DETAILS
Have you or a blood relative ever had a problem with general anaesthetic?			
Have you suffered from severe nausea after anaesthetic?			
Do you have problems with neck or jaw movement?			
Do you suffer from heartburn, indigestion or reflux?			
Do you have any capped teeth, loose teeth or dentures?			
Gastric band / sleeve gastrectomy / gastric bypass			Specify

04/11/2022 Print Code:10562 Page 3 of 5 LUW, Allanby & DMR e form

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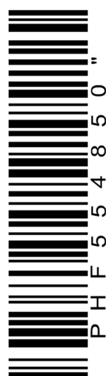

GENERAL	NO	YES	FURTHER DETAILS
Do you drink alcohol			How much per week? ....
Do you use illicit drugs?			If so which drugs .... How much per week? ....
Hepatitis, jaundice, cirrhosis or pancreatitis			Specify
Kidney disorder - stones, infection, failure, dialysis			Specify
Organ transplant			Specify
Stroke			When:
Epilepsy, fits, fainting or "funny turns"			
Significant back injury/disorder			
Significant neck injury/disorder			
Blood disorder *(leukaemia, anaemia, haemophilia or other)* - specify			
Blood transfusion and / or blood products			When? ....
Do you object to accepting blood products for a cultural / religious reason			
Blood clot in legs or lungs			Specify
Female patients only: Could you be pregnant?			Due Date: ....
Do you have mental health concerns / Depression / Anxiety ?			
Do you have Dementia / delerium / wandering?			
Do you have Intellectual Disability?			
Have you ever had a positive COVID-19 test?			Date: ....
Do you have any ongoing symptoms of COVID-19? *(e.g. cough, sore throat, shortness of breath, runny nose, or loss or change in sense of smell or taste, headache, nausea, diarrhoea,vomiting, malaise or myalgia, delirium, functional decline)* Have you ever been hospitalised with COVID-19?			Specify Which Hospital? .... Date: ....

How far on average can you walk?

Two or more blocks ☐ Around the shopping centre ☐ Housebound most of the time ☐

List any other serious illness or medical condition: ....

....

....

....

....

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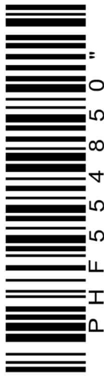

INFECTION CONTROL	NO	YES	FURTHER DETAILS
Are you aware of yourself or a family member being a carrier of Creutzfeldt - Jakob Disease (CJD)?			
Have you had MRSA (Methicillin Resistant Staphylococcus aureus) or Golden Staph?			
Have you had a VRE *(Vancomycin Resistant Enterococci)* infection?			
Have you had ESBL (Extended Spectrum Beta Lactamase)			
Have you had a overnight admission to hospital in the last 12 months at .... Overseas ☐			
In the last three months have you had a non-healing wound?			

OTHER HEALTH INFORMATION	NO	YES	FURTHER DETAILS
Do you have a problem with your speech?			
Do you have impaired eyesight? - Glasses / Contact Lens / Eye prosthesis / Legally blind			
Do you have impaired hearing? - Deaf / Hearing aid			
Has your bowel pattern changed recently? Constipation / Diarrhoea / Blood / Incontinence			
Do you have any problems passing urine? pain / odour / blood / incontinence / catheter			
Do you have a stoma? colostomy / ileostomy / ileal conduit / tracheostomy / laryngectomy			

DISCHARGE PLANNING	NO	YES	FURTHER DETAILS
Do you live alone			
Do you use any mobility aids such as a stick, frame, wheelchair?			If yes, which
Do you use any community support – home-help, meals on wheels, home visit services			If yes, which
Do you have someone who can stay with you overnight?			

If you are having a day procedure you must have somebody to collect you from the hospital and stay with you for 24 hours or your surgery will be postponed

Who will stay with you? - Name: .... Phone No. ....

Who will escort you home from hospital - Name: .... Phone No. ....

Signature of Person Completing Form: .... Date Signed: ....

Relationship to Patient (if not completed by the patient): ....