HEALTH QUESTIONNAIRE

To provide you with the best possible treatment. Please complete the following.

Orthopaedics Queensland

SURGEON

- ☐ Dr Ritesh Dawra
- ☐ Dr Charles Dick
- ☐ Dr Kim Latendresse
- ☐ Dr Jonathan Dick
- ☐ Dr Vasudev Navalgund
- ☐ Mr James Tunggal

PATIENT DETAILS

First Name _____ Surname _____ DOB _____

What Is Your Height (cm) _____ What Is Your Weight (kg) _____

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

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