NSW GOVERNMENT | Health
South Eastern Sydney
Local Health District

Facility: Prince of Wales Hospital

HYPERBARIC PATIENT HEALTH QUESTIONNAIRE

FAMILY NAME		MRN	
GIVEN NAME		☐ MALE	☐ FEMALE
D.O.B. ______/______/______	M.O.		
ADDRESS			
LOCATION / WARD			
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE			

Patient to complete: *Please answer the following questions ticking the appropriate box.*
Give necessary details in the spaces provided.

Have you had a Hospital admission within the last six months? ☐ YES ☐ NO
Details of admission: ______________________________

Are you currently under the care of any specialist doctors? ☐ YES ☐ NO

Reason for seeing doctor	Speciality

Do you use any regular medications? (e.g. prescription, non-prescription, recreational or herbal medicine) ☐ YES ☐ NO
If yes please list them below or attach list.

Name of medication	Dose	How often

Do you have any allergies? ☐ YES ☐ NO
If Yes please list them below and the type of reaction you have:

Drug or other agent	Reaction

What is your weight/height ______cm ______kg

Do you have access to regular transport to Randwick ☐ YES ☐ NO

Do you require an interpreter for the consultation? ☐ YES ☐ NO
If Yes, which language?______________________________

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BINDING MARGIN - NO WRITING

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HYPERBARIC PATIENT HEALTH QUESTIONNAIRE SES030.061

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COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Medical Checklist

Yes	No		Doctor's Comments
		Have you had Radiotherapy	
		• If yes – Which Hospital and when ____________	
		• Dose of radiation (if known) ____________	
		Have you had Chemotherapy	
		• If Yes – Which hospital and when____________	
		• Name of Chemotherapy agents *(if known)*	
		Have you ahd any medical or surgical tramtmeent overseas. If Yes when ____________	
		Have you ever had an infection with a multriesistant organisism (e.g. MRSA, VRE, CPE)	
		Any problems equalising your ears? ("popping ears")	
		Hearing problems or deafness (hearing aids)	
		Ear surgery	
		Chest pain or "angina"	
		Do you use home oxygen	
		Heart attack	
		Any other heart conditions (e.g. heart valve, pacemaker). If Yes to pacemaker please list Make and Model or any other device? ____________	
		Any chronic lung disease/condition	
		Have you been prescribed any puffers (e.g. Ventolin)?	
		Pneumothorax (collapsed lung)	
		Tuberculosis (TB)	
		Injury to chest (e.g. broken ribs)	
		Epilepsy or fits	
		Stroke	
		Fainting/blackouts or head injury	
		Do you have diabetes?	
		Do you use insulin?	
		Anxiety, panic attacks or claustrophobia	
		Eye visual problems (e.g. cataracts)	
		Are you pregnant or planning pregnancy?	
		Do you smoke: ____________ How many per day: ____________ For how long: ____________	Pack/Year history:
		Do you drink alcohol: ____________ How many per day: ____________	

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Patient Authority

Are you completing this form on behalf of the patient: ☐ YES ☐ NO

If Yes please note you need the patient's authority/agreement.

Please complete the following:

Your Family Name: ____________________ Your given name: ____________________

Relationship to patient: ______________________________________

Phone number: ____________________ Mobile number: ____________________

Your signature: ____________________

Patient's signature: ____________________

I certify the above information is true and complete to the best of my knowledge.

I authorise the Hyperbaric Unit at Prince of Wales Hospital to obtain or supply information pertaining to my health from or to other doctors:

Signed: ________________________ Date: ________________________

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