MACQUARIE UNIVERSITY Hospital

**Macquarie University Hospital**

| | |
|---|---|
| Name: | **Morrison, Raymond**, Male |
| DOB: | **19/08/1985** (39 years) |
| Street Address: | 40 TOLEDO CCT |
| Suburb/Town: | PORT KENNEDY WA 6172 |
| Phone(h): | |
| Phone(m): | 0459570046 |

# Patient Health Questionnaire

## THIS HOSPITAL VISIT

| | |
|---|---|
| Admission type | Surgical - overnight |
| Reason for admission | Amputation |
| Admission date | 11/07/2025 |
| Admitting Dr Name | Al Muderis , Munjed |

## LEGAL INFORMATION

| | |
|---|---|
| Advance Care Directive | No |
| Enduring Guardian | No |
| Power of Attorney | No |

## PREADMISSION TESTS

| | |
|---|---|
| Blood tests this admission | No |
| Any x-rays, scans, ultrasounds | YES |
| Where are the copies | With my doctor |

## DIABETES / ENDOCRINE PROBLEMS

| | |
|---|---|
| Diabetes | No |
| Thyroid abnormalities / other endocrine | No |

## HEART AND CIRCULATORY PROBLEMS

| | |
|---|---|
| Chest pain/angina | No |
| Heart attack | No |
| High blood pressure / hypertension | No |
| Low blood pressure | No |
| Elevated cholesterol / triglycerides | No |
| Family history of cardiac disease | No |
| Seeing cardiologist? | No |
| Palpitations / heart murmur / AF | No |
| Rheumatic fever | No |
| Congestive cardiac failure | No |
| Pacemaker / Internal Cardiac Defibrillator | No |
| Coronary artery bypass | No |
| Angiogram | No |
| Coronary / vascular stent | No |
| Artificial heart valve | No |
| Other Heart Surgery | No |

## RESPIRATORY / SLEEP PROBLEMS

| | |
|---|---|
| Respiratory issues affect mobility | No |
| Asthma | No |

| | | |
|---|---|---|
| Receiving Home O2 | No | |
| Emphysema /COAD /COPD / other obstructive breathing disease | No | |
| Uses CPAP / breathing device | No | |
| Other respiratory problems | No | |
| Sleep apnoea / snoring / interrupted breathing | YES | Loud Snoring/Blocked sinus |
| Difficulties sleeping /sleeping disorders? | YES | Nightmares |

## BODY MEASURES

| | |
|---|---|
| Height (cm) | 186 |
| Weight (kg) | 115 |
| BMI (kg/m2) | 33 |

## ANAESTHETIC RISK DETAILS

| | |
|---|---|
| Malignant hyperthermia (self) | No |
| Malignant hyperthermia (family) | No |
| Problems anaesthetic (self or family) | No |

## ALLERGY DETAILS

| | |
|---|---|
| Any allergies | YES |
| Latex allergy | No |
| Adhesive tape allergy | No |

| Allergy | Type | Reaction |
|---|---|---|
| Lactose | Food | Stomach cramps and Diarrehia |
| Pineapple | Food | Tongue Swells up |

## MEDICATION DETAILS

| | |
|---|---|
| On medication for diabetes? | No |
| Blood thinning medications | No |
| Steroid medications | No |
| Pain medications | No |
| Please specify | |
| Any medications? | YES |

| Name | Amount | How Often | Purpose |
|---|---|---|---|
| Neoral Capsules 100 mg Capsules | 2 | Twice Daily | Psoriasis |

## BLOOD DISORDERS

| | |
|---|---|
| Diagnosed with anaemia | No |
| Blood disorders eg Haemophilia | No |
| Blood clot legs or lungs (DVT or PE) | No |
| Had blood transfusion | No |
| Blood disorders | No |

## NEUROLOGICAL AND MENTAL HEALTH

| | | |
|---|---|---|
| Mental health conditions | YES | C-PTSD, ADHD, ADD, Anxiety, Depression |
| Currently receiving treatment | No | |
| Recurring headaches / migraines | No | |
| Stroke / Mini Stroke / TIA | No | |
| Fainting or dizzy spells | No | |
| Epilepsy / fits / seizures | No | |
| Dementia / memory loss / Delirium | No | |

| | | |
|---|---|---|
| Speech / swallowing problems | No | |
| Fallen last 12 months | No | |
| Brain infection or inflammation | No | |
| Other neurological | No | |
| Nerve stimulator implant | No | |
| Shunt | No | |
| Paraplegic or quadraplegic | No | |

## BONE AND JOINT

| | | |
|---|---|---|
| Arthritis | No | |
| Osteoporosis / low bone density | No | |
| Limited neck movement | No | |
| Ever had fracture | YES | Fracted ribs and Shoulder Blade |
| Mobility issues | YES | CRPS in Right lower Leg |
| Other bone or joint | No | |
| Metal plates / pins | No | |
| Joint replacements | No | |
| Other implants / devices | No | |

## GASTROINTESTINAL

| | |
|---|---|
| Reflux / stomach ulcer | No |
| Hiatus hernia | No |
| Bowel problems | No |
| Constipation | No |
| Colostomy or ileostomy | No |
| Fistulas or stomas | No |
| Weight loss surgery | No |
| Any other gastrointestinal surgery | No |
| Other gastrointestinal problems | No |
| Liver problems / disease | No |

## KIDNEY AND BLADDER PROBLEMS

| | |
|---|---|
| Kidney disease / renal failure | No |
| Nephrectomy (kidney removal) | No |
| Bladder problems | No |
| Do you have prostate problems? | No |
| On dialysis | No |
| Dialysis fistulae | No |

## OTHER SIGNIFICANT MEDICAL HISTORY

| | |
|---|---|
| Ever had (or currently have) cancer | No |
| Transplants | No |
| Other previous surgery | No |

## INFECTION SCREENING

| | |
|---|---|
| Recent cold | No |
| Current infection | No |
| Vomited last 2 weeks | No |
| Diarrhoea last week | No |
| Flu like symptoms and recent O/S travel | No |
| Admitted to overseas facility last 12 months | No |
| MRO | No |

| | | |
|---|---|---|
| Infected or colonised with CPE | No | |
| Prescribed Vancomycin long period | No | |
| Ever had tuberculosis? | No | |
| CJD family history | No | |
| Acute dementia or progressive neurological illness | No | |
| Human pituitary hormone treatment pre 1986? | No | |
| Dura mater graft pre 1990 | No | |
| CJD Lookback study | No | |

## LIFESTYLE AND DIET

| | | |
|---|---|---|
| Smoking status | Past smoker | |
| Daily amount smoked | 10 | |
| Date ceased | 8/11/2024 | |
| Drink alcohol | No | |
| Recreational drug use | No | |
| Any special dietary needs? | YES | |
| Special diets | Lactose Intolerant<br>Gluten Free | |
| Lost weight without trying | No | |
| Eating poorly / lost appetite | No | |
| Meals assistance required * | No | |
| Peg tube | No | |
| Tracheostomy | No | |

## SKIN INTEGRITY

| | | |
|---|---|---|
| Skin problems | YES | All over<br>Psoriasis |

## DENTAL

| | | |
|---|---|---|
| Dentures | No | |
| Limited jaw movement | No | |
| Caps | No | |
| Crowns | No | |
| Loose or broken teeth | YES | |
| Additional dental problems | No | |

## AIDS, IMPAIRMENTS AND MOBILITY

| | | |
|---|---|---|
| Impairment of vision | No | |
| Impairment of hearing | No | |
| Impairment of speech | No | |
| Impairment of mobility | YES | Wheelchair<br>Crutches |
| Any other aids | No | |

## OTHER GENERAL HEALTH DETAILS

| | | |
|---|---|---|
| Chronic pain | YES | CRPS lower right Leg |

## DISCHARGE PLANNING

| | | |
|---|---|---|
| Do you live alone? | No | |
| Caring responsibility for others | YES | Father of 6 |
| Assistance with ADLs | No | |
| Concerns about managing at home | YES | House is not very Amputee friendly |

| | |
|---|---|
| Discuss needs before admission | No |
| Any other medical conditions | No |

## UPLOAD YOUR SUPPORTING DOCUMENT(S)

Upload file

## REVIEW AND SUBMIT

| | |
|---|---|
| Acknowledge form complete and correct | Pending |