HEALTH QUESTIONNAIRE

ADMISSION DETAILS	**DATE COMPLETED:**
Patient Name: _____	Date of Birth: _____

ALLERGIES - have you had a reaction to Details: *please include substance and type of reaction*

☐ Y ☐ N Plaster_____
☐ Y ☐ N Iodine/Savlon_____
☐ Y ☐ N Food (including seafood/shellfish) _____
☐ Y ☐ N Latex_____

GENERAL QUESTIONS

☐ Y ☐ N Unpredictable/Persistent Cough
☐ Y ☐ N Hepatitis A/B/C/HIV
☐ Y ☐ N MRSA
☐ Y ☐ N Skin or other infection
☐ Y ☐ N Can you lie flat for 30-45 mins?
☐ Y ☐ N Are you on any blood thinners?

Questionnaire completed by ☐ Patient ☐ Family Member ☐ Staff

To the best of my knowledge the above information is correct

Name: _____

Signature: _____ Date: _____