



## PATIENT HEALTH HISTORY

**(Do you suffer from or have you ever had any of the following?)** Please answer all the questions

- 9** High blood pressure? Y  N   
*If Yes, is this being monitored/treated by your GP?*  
\_\_\_\_\_
- 10** Heart problems (eg heart attack, angina, irregular pulse, fluid on lungs, **PACEMAKER**, rheumatic fever, palpitations, fainting, murmur, endocarditis)? Y  N   
*If Yes, please list:*  
\_\_\_\_\_
- 11** Blood disorders: (eg anaemia, Von Willebrands disease)? Y  N   
*If Yes, please explain:*  
\_\_\_\_\_
- 12** Asthma? Y  N
- 13** Lung problems (eg recent bronchitis, emphysema, TB)? Y  N
- 14** A stroke (eg CVA, or TIA)? Y  N
- 15** Fits or seizures (eg epilepsy)? Y  N   
*If Yes, when was your last seizure?*  
\_\_\_\_\_
- 16** Hepatitis A  Hepatitis B  Hepatitis C  Yellow Jaundice  HIV
- 17** Diabetes? Y  N   
*If Yes, what treatment are you on? Diet                      Tablets                      Insulin*  
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- 18** Blood clots to legs or lungs? Y  N
- 19** Rheumatoid Arthritis? Y  N
- 20** Hiatus Hernia  Heartburn  Acid Reflux
- 21** Are you, or could you, be pregnant? Y  N
- 22** Any other medical conditions (eg Alzheimer's, psychiatric history)? Y  N   
*If Yes, please specify:*  
\_\_\_\_\_  
\_\_\_\_\_

### Discharge Planning

- 23** Do you live alone? Y  N
- 24** Do you have caring responsibilities for others at home? Y  N
- 25** Do you receive Home Health Services (eg Meals on Wheels, District Nurse)? Y  N