WIRES
Interventional Radiology

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Health Assessment Questionnaire

Patient Details:

FULL NAME | DATE OF BIRTH

ADDRESS | PHONE

This HAQ allows your doctor to evaluate various aspects of your physical, mental and psychosocial health relevant to your care. Please answer them to the best of your ability. If you encounter any questions that you prefer not to answer, you may leave them blank and your doctor can address these during your appointment.

Do you have the following? If answered 'Yes', please elaborate in *Details*:

Cardiovascular:	NO	YES	Details:
1. High blood pressure	☐	☐	
2. Angina or chest pain	☐	☐	
3. Shortness of breath on exertion ie one flight of stairs	☐	☐	
4. Previous heart attack	☐	☐	
5. Heart failure	☐	☐	
6. Abnormal heart rhythm, including atrial fibrillation	☐	☐	
7. Replaced heart valve	☐	☐	
8. Coronary artery stent	☐	☐	
9. Coronary bypass graft surgery	☐	☐	
10. Other heart conditions ie murmur, enlarged heart	☐	☐	
Respiratory:			
11. Emphysema/asthma	☐	☐	
12. Other lung disease ie interstitial lung disease, asbestos, TB	☐	☐	
– If 'yes', home oxygen requirement	☐	☐	
13. Sleep apnoea	☐	☐	
– If 'yes', do you require CPAP	☐	☐	
14. Chronic cough or shortness of breath	☐	☐	
Neurological/mental health:			
15. Previous stroke, TIAs or ministrokes	☐	☐	
16. Carotid artery stent	☐	☐	
17. Epilepsy or fits	☐	☐	
18. Neurodegenerative disorder ie dementia, Parkinson's disease	☐	☐	
19. Mental health issues ie anxiety, depression, bipolar disease, schizophrenia, schizoaffective disease, addiction	☐	☐	
Haematology:			
20. Previous blood clots in legs (DVT) or lungs (PE)	☐	☐	
21. Blood clotting disorders	☐	☐	
Renal:			
22. Kidney disease	☐	☐	
23. Dialysis – If 'yes', peritoneal or haemodialysis	☐	☐	

Gastrointestinal & urogenital:

	NO	YES	Details:
24. Cirrhosis	☐	☐	
25. Choking, regurgitation or reflux when lying down	☐	☐	
26. Recent loss of weight or appetite	☐	☐	
27. Recurrent urinary tract infection	☐	☐	
28. Incontinence, bowel or urinary	☐	☐	
29. Urinary retention requiring catheterisation	☐	☐	

Anaesthesia:

30. Issues with sedation, local or general anaesthesia in the past	☐	☐	
31. Family history of malignant hyperthermia	☐	☐	
32. Removable dentures	☐	☐	

Musculoskeletal:

33. Rheumatoid arthritis	☐	☐	
34. Spine problems	☐	☐	
35. Jaw problems ie trismus, TMJ arthritis or syndrome	☐	☐	

Active infections:

36. Tuberculosis	☐	☐	
37. Hepatitis B or C	☐	☐	
38. HIV	☐	☐	
39. Other	☐	☐	

Cancer:

40. Active cancer	☐	☐	
41. Previous cancer	☐	☐	

If you are having a Port, Hickman, Permacath or tunnelled line inserted:

42. Pacemaker – If 'yes', state side	☐	☐	
43. Previous Port, Hickman or Permacath – If 'yes', state side	☐	☐	
44. Previous mastectomy – If 'yes', state side	☐	☐	
45. Previous axillary lymph node dissection – If 'yes', state side	☐	☐	

Substance (includes current and previous history):

46. Alcohol	☐	☐	Standard drinks per week:
47. Cigarette smoked	☐	☐	Years smoked: Packets daily: Active/Year quit:
48. Vape	☐	☐	
49. Illicit drugs	☐	☐	

Living arrangement:

50. Live alone, in a hostel, or nursing home	☐	☐	
51. Have a carer	☐	☐	
52. Need help with self care ie bathing, dressing	☐	☐	
53. Look after someone as a primary carer	☐	☐	
54. Use community care service	☐	☐	

Medications:

55. Blood thinners	☐	☐	
56. Pain medications	☐	☐	

Other comments:

Do you have any allergies? If yes, please provide details to the table below

DRUG (OR OTHER)	REACTION

Please provide a complete list of your current medications, including over the counter supplements. *Alternatively, you may bring or email a copy of your medication list:*

MEDICATION NAME & STRENGTH	NO. OF TABLETS	FREQUENCY	ROUTE (IF NOT ORAL)
Asprin 100mg	*1 tablet*	*Daily*	
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Send completed Health Assessment Questionnaire & Medication List to:

Fax: 03 9088 8112 | Email: admin@wiresradiology.com.au

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