Sint-Jozef kliniek

Patient ID sticker

(Label of the Hospital, affixed by a Staff Member upon registration)

# Questionnaire about self-medication

In preparation for your hospitalization at the Sint-Jozefkliniek in Bornem or Willebroek, we ask that you complete the following medical questionnaire **with attention**. In an effort to provide you with the best possible care, it is very important for us to have a detailed inventory of all medication you take. If you need assistance, please ask your family, doctor, pharmacist or nurse for further information.

If you currently do not take any medication, please check this box. ☐

NAME: ..... FIRST NAME: .....

DATE OF BIRTH: ..... ADMISSION DATE: .....

HOUSE DOCTOR (+ ZIP CODE) .....

YOUR PHARMACY (+ ZIP CODE) .....

**PLEASE SPECIFY BELOW THE MEDICATIONS YOU TAKE. TRY TO GIVE AS MANY DETAILS AS POSSIBLE. FOR EACH MEDICINE, WRITE DOWN ITS COMPLETE NAME AND THE BRAND AS SHOWN ON THE PACKAGING. BRING YOUR MEDICINES IN THE ORIGINAL PACKAGING.**

| Name of the medicine (product and company name) | Dosage (mg,ml) | Route of medication: oral, suppository, injection, catheter, etc. | Dosage : How many times a day? | What time of day? | How long have you been taking this medication? | When did you take your last dose? |
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Maatschappelijke zetel: Kasteelstraat 23 | 2880 Bornem | Tel. 03 890 16 11 | Fax: 03 890 16 08
info@sjk.be | www.sjk.be | vzw | Stamnr. RIZIV 7/10.104/33 – RPR 0416 851 659

**PLEASE ANSWER THE FOLLOWING QUESTIONS:**

1. Are you in charge of your own medication? ☐ Yes ☐ No
   **If not,** who prepares your medicines? ……
2. Do you suffer from allergies? ☐ Yes ☐ No

   **If yes,** which ones? ……
3. Do you take anticoagulants? ☐ Yes ☐ No

   If you've taken some in the past, when did you stop? ……..

   Did you receive an alternative medication? (An injection for instance)? ☐ Yes ☐ No

   **If so**, when? ……
4. Do you use asthma inhalers? Which one(s)?…… ☐ Yes ☐ No
5. Do you take painkillers? Which one(s)? ☐ Yes ☐ No

   (Name) …… Quantity?…… Frequency?.....

   (Name) …… Quantity?…… Frequency?.....
6. Do you use patches? ☐ Yes ☐ No
7. Did you recently take antibiotics? (less than 2 weeks ago) ☐ Yes ☐ No

   **If yes**, which one(s)? ……..
8. Do you take sleeping pills? ☐ Yes ☐ No
9. Do you do your injections yourself? (ex. Clexane, Fraxiparine, insulin, etc.) ☐ Yes ☐ No
10. Are you currently following a hormone treatment? ☐ Yes ☐ No
11. Do you have to take medications once a week/month/…? Which one(s)? ☐ Yes ☐ No

    (Name) …… Quantity?…… Frequency?.....

    (Name) …… Quantity?…… Frequency?.....
12. Did you recently stop a medication? **If yes**, which one(s)? ☐ Yes ☐ No
    (Name) …… When did you stop? ……
13. Do you use eye drops? ☐ Yes ☐ No
14. Do you use a cream/lotion? **If yes**, which one(s)?…… ☐ Yes ☐ No
15. Do you use products made by your Pharmacist (magistral preparation)? ☐ Yes ☐ No

    **If yes**, which one(s)?……
16. Do you take dietary supplements or homeopathic pills? ☐ Yes ☐ No

    **If yes**, which one(s)?……

***Thank you for your help !***

FILLED IN BY: …… DATE: ……

SIGNATURE:



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