

# Health Questionnaire



## Important!

Please deliver, post, or email this form 7–10 working days before your admission together with the completed Admission, Finance and Consent Form to:

Wakefield Hospital  
Private Bag 7909  
Wellington South 6242

Email: [reception@wakefield.co.nz](mailto:reception@wakefield.co.nz)

A stamped, addressed envelope is provided for posting. If this is not possible, please make sure you bring the forms with you when you arrive for admission. If you emailed the forms to us, please bring the originals with you.

## Personal Details (patient to complete)

Admission Date:

**Personal details:**

Mr/Ms/Mrs/Miss/Dr

First name Middle name Surname

Preferred Name  Date of birth  Age  NHI No:

Known as If known

Gender  Ethnicity  Are you: NZ Citizen  Permanent resident

Email

Telephone

Home Work Mobile

If you have ever had any of the following medical conditions, please tick 'Yes' or 'No' and provide further details if applicable.

Cardiac	YES	NO	COMMENTS
High blood pressure?	<input type="radio"/>	<input type="radio"/>	.....
Have you ever had any problems with your heart or blood vessels?	<input type="radio"/>	<input type="radio"/>	.....
Chest pain or discomfort? Angina?	<input type="radio"/>	<input type="radio"/>	.....
Have you ever had a heart attack?	<input type="radio"/>	<input type="radio"/>	.....
Palpitations or irregular heartbeat?	<input type="radio"/>	<input type="radio"/>	.....
Any procedures, operations or investigations on your heart: surgery, stents, heart valve replacement, or an Implanted cardiac defibrillator (ICD) or Pacemaker?	<input type="radio"/>	<input type="radio"/>	.....
Do you have any problems with your circulation or ever had any operations on your veins or arteries?	<input type="radio"/>	<input type="radio"/>	.....
Respiratory	YES	NO	COMMENTS
Asthma or chronic airways disease (COPD)?	<input type="radio"/>	<input type="radio"/>	.....
Any other lung or breathing problems?	<input type="radio"/>	<input type="radio"/>	.....
Chest infections?	<input type="radio"/>	<input type="radio"/>	.....
Have you had a chest infection in the last four weeks and did it require steroids/medication to treat? <i>Please provide details if yes.</i>	<input type="radio"/>	<input type="radio"/>	.....
Loud snoring (that can be heard from other rooms)?	<input type="radio"/>	<input type="radio"/>	.....
Sleep aponea (or have you been told you stop breathing while asleep?)	<input type="radio"/>	<input type="radio"/>	.....
Do you use a CPAP machine?	<input type="radio"/>	<input type="radio"/>	.....

**Endocrine (glands), hormonal disorders and diabetes**

**YES NO COMMENTS**

Diabetes?  YES  NO Type 1  Type 2

Do you currently use: Insulin  Tablets  Diet control  *Please bring blood sugar recordings with you if available.*

Any other endocrine, hormone or gland problems?  YES  NO .....

Thyroid problems?  YES  NO .....

Adrenal or pituitary problems?  YES  NO .....

**Kidney and urinary systems**

**YES NO COMMENTS**

Kidney (renal) condition? (e.g. only one kidney, dialysis)  YES  NO .....

Kidney stones?  YES  NO .....

Urinary problems? (e.g. Recurrent infection, bed wetting.)  YES  NO .....

Any other kidney or urinary problems?  YES  NO .....

**Neurological**

**YES NO COMMENTS**

Do you have any problems or under treatment for any neurological condition?  YES  NO .....

Stroke, Cerebrovascular accident (CVA), or Transient Ischaemic Attack or (TIA)  YES  NO .....

Seizures, blackouts or fainting relating to epilepsy? If yes, how often do you have seizures? When was the last time?  YES  NO .....

Dementia or cognitive problems? (Alzheimer's, forgetfulness)  YES  NO .....

Paraplegia or spinal problems?  YES  NO .....

Muscle or Neurological disease e.g. MS, Parkinson's, Muscular dystrophy  YES  NO .....

CJD or any neurological disease currently under investigation?  YES  NO .....

**Liver**

**YES NO COMMENTS**

Hepatitis A, B, C, jaundice or liver condition?  YES  NO .....

Cirrhosis?  YES  NO .....

Gallstones?  YES  NO .....

Any other problems?  YES  NO .....

**Blood disorders**

**YES NO COMMENTS**

Blood clots in lungs or legs? (PE, DVT, thrombosis?)  YES  NO .....

Bleeding disorder and/or family history (von Willebrands disease/hemophilia)  YES  NO .....

Anaemia?  YES  NO .....

Previous blood transfusion? If yes, when was the last, and what was the reason?  YES  NO .....

**Gastrointestinal****YES NO COMMENTS**

- Gastric reflux or hiatus hernia?  YES  NO .....
- If yes, is your heartburn well controlled?  
Please provide details.  YES  NO .....
- Any other gastrointestinal issues or procedures?  YES  NO .....
- Inflammatory bowel disease e.g. Crohns or  
Ulcerative Colitis?  YES  NO .....
- Diverticular disease?  YES  NO .....
- Any surgery on your bowels or stomach?  YES  NO .....
- Cancer?  YES  NO .....

**Bones and joints****YES NO COMMENTS**

- Arthritis/Rheumatoid arthritis?  YES  NO .....
- Joint replacement or orthopaedic metalware?  YES  NO .....
- Other issues?  YES  NO .....

**Skin****YES NO COMMENTS**

- Do you have any eczema/skin conditions?  YES  NO .....
- Do you currently have any cuts, scratches, sores  
or abrasions on your skin?  YES  NO .....

**Infection****YES NO COMMENTS**

- Are you a healthcare professional or have you  
stayed in hospital during the last 6 months?  YES  NO .....
- Travelled overseas in the last 6 months?  
If so, where and were you hospitalised?  YES  NO .....
- Transmittable diseases e.g. Hepatitis B or C,  
Tuberculosis, or HIV?  YES  NO .....
- Have you ever had a drug resistant infection?  
(MRSA, VRE, ESBL, VRSA)  YES  NO .....
- Have you had a blood transfusion in Europe 1980-1996  
or a human tissue transplant prior to 1992?  YES  NO .....
- Have you received human pituitary gonadotrophin  
or growth hormone prior to 1990?  YES  NO .....
- Have you had COVID-19? (Coronavirus). If yes, are you  
under any treatment or monitoring for this condition?  YES  NO .....
- Have you had or been in contact with someone with  
COVID-19? (Coronavirus). If so when?  YES  NO .....

**Mental health and wellbeing****YES NO COMMENTS**

- Do you suffer from anxiety, depression, PTSD or  
emotional disturbance or phobias e.g. needles?  YES  NO .....

**Chronic pain****YES NO COMMENTS**

- Do you have any chronic pain issues? If yes, what is  
the location of the pain? How is this being managed?  YES  NO .....

**Other** YES NO COMMENTS

Have you ever been investigated or treated for cancer?  YES  NO .....

Is there any other relevant medical condition you need to tell us about?  YES  NO .....

**Allergies, adverse reactions and food intolerances** YES NO Please describe the reaction

Do you have a latex allergy?  YES  NO .....

Other allergies  YES  NO .....

Adverse reactions e.g. medications or medical products  YES  NO .....

Food intolerances  YES  NO .....

**Medications**

Please list all medications you currently take including the dose and how often you take the medication in a day. This includes tablets, injections, contraceptive pills, inhalers, puffers, eye drops, patches etc. Alternatively, if your pharmacist provides you with a pre-filled multi-pack, ask for a printout of the medications you are currently taking. Please also include over-the-counter and any complementary, herbal, homeopathic or other alternative therapies.

Name	Dose	When do you take your medication?	Why do you take the medication?
.....			
.....			
.....			
.....			

**Health professionals**

List the name(s) of the hospital/clinic/doctors/surgeons/nurses you see.

Name	Reason for seeing	Date of last visit
.....		
.....		
.....		

**Previous surgery/anaesthesia** YES NO

Have you ever had surgery or been admitted to hospital before?  YES  NO

Operation/illness	Year	Hospital
.....		
.....		
.....		

**Anaesthesia related issues** YES NO Please describe the reaction

Do you have or have you ever had any of the following? If 'yes' or if you are uncertain, please comment in the box.

Have you ever had any problems with a previous surgery or recovery?  YES  NO .....

Do you have any jaw or neck problems?  YES  NO .....

    If yes, do you have any difficulty opening your mouth wide?  YES  NO .....

    Do you have any restrictions in your head or neck movement?  YES  NO .....

    Do you have any jaw problems e.g. jaw locking?  YES  NO .....

**Anaesthesia related issues cont.****YES NO****Please describe the reaction**

Have you been told you are difficult to intubate?

 

.....

Are there any conditions that run in your family?  
(e.g. malignant hyperthermia, thalassaemia, muscular dystrophy?) 

.....

Have you had any problems while under an anaesthetic?  
(e.g. slow to wake, nausea and vomiting, post surgery confusion, agitation) 

.....

Has any blood relative had problems while under an anaesthetic?

 

.....

**Dietary needs**

The nurse will ask you for more information on any dietary requirements you may have.

**YES NO**

Do you have any dietary requirements?

 

Please check any dietary requirements you have:

Gluten free  Dairy free  Lactose free  Pescatarian  Vegetarian  Vegan  Keto  FOD map 

Other

**Fitness and lifestyle**

How would you describe your general health?

Good  Fair  Poor 

Do any symptoms limit your ability to exercise?

E.g. breathlessness, chest pain, pain in joints, leg pain.

YES  NO 

.....

Have you ever smoked?

YES  Ex smoker  Never 

Do you currently smoke tobacco, eCigarettes or vape?

If yes, please provide details e.g. how many per day?

YES  NO 

.....

Do you smoke recreational drugs?

If so, what and how often?

YES  NO 

.....

Do you drink alcohol regularly?

If yes, how many units per week?

YES  NO 

.....

Are you or do you think you may be pregnant?

If yes, how many weeks?

YES  NO 

.....

**Communication and culture****YES NO****Comments**

Do you have a visual or hearing impairment?

 

Hearing aids or glasses? .....

Do you have any cultural needs we should be aware of?

 

.....

Do you speak English fluently?

 

If no, which language? .....

*If an external interpreter service is required, this will incur an additional cost.*

Blood transfusions: Do you have any reasons which might stop you from accepting a blood transfusion?

 

.....

Human tissue: Would you like surgically removed body parts to be returned? (Excludes metalware)

 

.....

**Discharge planning**

**YES NO Comments**

To help the nurses plan your discharge home after your operation, we need to ask you a few general questions.

Do you require any physical support or aids? If so, what?	<input type="radio"/>	<input type="radio"/>	.....
Do you live alone? If yes, and your surgery is booked as a day case, have you arranged for an adult to take you home and stay with you overnight? If yes, please give detail.	<input type="radio"/>	<input type="radio"/>	.....
Do you have any dependents?	<input type="radio"/>	<input type="radio"/>	.....
Do you have any pets?	<input type="radio"/>	<input type="radio"/>	.....
Do you have any problems with daily activities? Can you manage around the house? With or without mobility aids? (e.g. showering, bathing, dressing)	<input type="radio"/>	<input type="radio"/>	.....
Do you have stairs at home?	<input type="radio"/>	<input type="radio"/>	.....
Have you had a fall in the last 6 months?	<input type="radio"/>	<input type="radio"/>	.....
Will someone be taking you home?	<input type="radio"/>	<input type="radio"/>	.....
Do you have someone to stay overnight with you when you get home?	<input type="radio"/>	<input type="radio"/>	.....
Are you currently using any community support services? If so, please list.	<input type="radio"/>	<input type="radio"/>	.....
Do you have any other concerns about your discharge?	<input type="radio"/>	<input type="radio"/>	.....
Do you have a disability we should be aware of?	<input type="radio"/>	<input type="radio"/>	.....
Would you like us to phone you after discharge?	<input type="radio"/>	<input type="radio"/>	.....
What is the best contact number to reach you on following the first few days after your discharge?			.....