

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

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 Gender Ethnicity Are you: NZ Citizen Permanent resident

Email

Telephone

Home Work Mobile

Patient's height Patient's weight

Surgeon's Name Procedure Undergoing

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

Endocrine (glands), hormonal disorders and diabetes

	YES	NO	COMMENTS
Diabetes?	<input type="radio"/>	<input type="radio"/>	Type 1 <input type="radio"/> Type 2 <input type="radio"/>
Do you currently use: Insulin <input type="radio"/>	Tablets <input type="radio"/>		Diet control <input type="radio"/> <i>Please bring blood sugar recordings with you if available.</i>
Any other endocrine, hormone or gland problems?	<input type="radio"/>	<input type="radio"/>
Thyroid problems?	<input type="radio"/>	<input type="radio"/>
Adrenal or pituitary problems?	<input type="radio"/>	<input type="radio"/>

Kidney and urinary systems

	YES	NO	COMMENTS
Kidney (renal) condition? (e.g. only one kidney, dialysis)	<input type="radio"/>	<input type="radio"/>
Kidney stones?	<input type="radio"/>	<input type="radio"/>
Urinary problems? (e.g. Recurrent infection, bed wetting.)	<input type="radio"/>	<input type="radio"/>
Any other kidney or urinary problems?	<input type="radio"/>	<input type="radio"/>

Neurological

	YES	NO	COMMENTS
Do you have any problems or under treatment for any neurological condition?	<input type="radio"/>	<input type="radio"/>
Stroke, Cerebrovascular accident (CVA), or Transient Ischaemic Attack or (TIA)	<input type="radio"/>	<input type="radio"/>
Seizures, blackouts or fainting relating to epilepsy? If yes, how often do you have seizures? When was the last time?	<input type="radio"/>	<input type="radio"/>
Dementia or cognitive problems? (Alzheimer's, forgetfulness)	<input type="radio"/>	<input type="radio"/>
Paraplegia or spinal problems?	<input type="radio"/>	<input type="radio"/>
Muscle or Neurological disease e.g. MS, Parkinson's, Muscular dystrophy	<input type="radio"/>	<input type="radio"/>
CJD or any neurological disease currently under investigation?	<input type="radio"/>	<input type="radio"/>

Liver

	YES	NO	COMMENTS
Hepatitis A, B, C, jaundice or liver condition?	<input type="radio"/>	<input type="radio"/>
Cirrhosis?	<input type="radio"/>	<input type="radio"/>
Gallstones?	<input type="radio"/>	<input type="radio"/>
Any other problems?	<input type="radio"/>	<input type="radio"/>

Blood disorders

	YES	NO	COMMENTS
Blood clots in lungs or legs? (PE, DVT, thrombosis?)	<input type="radio"/>	<input type="radio"/>
Bleeding disorder and/or family history (von Willebrands disease/hemophilia)	<input type="radio"/>	<input type="radio"/>
Anaemia?	<input type="radio"/>	<input type="radio"/>
Previous blood transfusion? If yes, when was the last, and what was the reason?	<input type="radio"/>	<input type="radio"/>

Gastrointestinal	YES	NO	COMMENTS
Gastric reflux or hiatus hernia?	<input type="radio"/>	<input type="radio"/>
If yes, is your heartburn well controlled? Please provide details.	<input type="radio"/>	<input type="radio"/>
Any other gastrointestinal issues or procedures?	<input type="radio"/>	<input type="radio"/>
Inflammatory bowel disease e.g. Crohns or Ulcerative Colitis?	<input type="radio"/>	<input type="radio"/>
Diverticular disease?	<input type="radio"/>	<input type="radio"/>
Any surgery on your bowels or stomach?	<input type="radio"/>	<input type="radio"/>
Cancer?	<input type="radio"/>	<input type="radio"/>

Bones and joints	YES	NO	COMMENTS
Arthritis/Rheumatoid arthritis?	<input type="radio"/>	<input type="radio"/>
Joint replacement or orthopaedic metalware?	<input type="radio"/>	<input type="radio"/>
Other issues?	<input type="radio"/>	<input type="radio"/>

Skin	YES	NO	COMMENTS
Do you have any eczema/skin conditions?	<input type="radio"/>	<input type="radio"/>
Do you currently have any cuts, scratches, sores or abrasions on your skin?	<input type="radio"/>	<input type="radio"/>

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

Mental health and wellbeing	YES	NO	COMMENTS
Do you suffer from anxiety, depression, PTSD or emotional disturbance or phobias e.g. needles?	<input type="radio"/>	<input type="radio"/>

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?	<input type="radio"/>	<input type="radio"/>

Other**YES NO****COMMENTS**

Have you ever been investigated or treated for cancer?

Is there any other relevant medical condition you need to tell us about?

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

Do you have a latex allergy?

Other allergies

Adverse reactions e.g. medications or medical products

Food intolerances

 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?

 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?

Do you have any jaw or neck problems?

If yes, do you have any difficulty opening your mouth wide?

Do you have any restrictions in your head or neck movement?

Do you have any jaw problems e.g. jaw locking?

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?		