# Health Questionnaire

Wakefield HOSPITAL

## Important!

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

*Email: reception@wakefield.co.nz*

*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)

Admisson Date:

**Personal details:**

Mr/Ms/Mrs/Miss/Dr

*First name* *Middle name* *Surname*

Preferred Name *Known as* Date of birth Age NHI No: *If known*

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? | ☐ | ☐ | ..... |
| Have you ever had any problems with your heart or blood vessels? | ☐ | ☐ | ..... |
| Chest pain or discomfort? Angina? | ☐ | ☐ | ..... |
| Have you ever had a heart attack? | ☐ | ☐ | ..... |
| Palpitations or irregular heartbeat? | ☐ | ☐ | ..... |
| Any procedures, operations or investigations on your heart: surgery, stents, heart valve replacement, or an Implanted cardiac defibrillator (ICD) or Pacemaker? | ☐ | ☐ | ..... |
| Do you have any problems with your circulation or ever had any operations on your veins or arteries? | ☐ | ☐ | ..... |

| Respiratory | YES | NO | COMMENTS |
|---|---|---|---|
| Asthma or chronic airways disease (COPD)? | ☐ | ☐ | ..... |
| Any other lung or breathing problems? | ☐ | ☐ | ..... |
| Chest infections? | ☐ | ☐ | ..... |
| Have you had a chest infection in the last four weeks and did it require steroids/medication to treat? *Please provide details if yes.* | ☐ | ☐ | ..... |
| Loud snoring (that can be heard from other rooms)? | ☐ | ☐ | ..... |
| Sleep aponea (or have you been told you stop breathing while asleep?) | ☐ | ☐ | ..... |
| Do you use a CPAP machine? | ☐ | ☐ | ..... |

| Endocrine (glands), hormonal disorders and diabetes | YES | NO | COMMENTS |
|---|---|---|---|
| Diabetes? | ☐ | ☐ | 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? | ☐ | ☐ | ..... |
| Thyroid problems? | ☐ | ☐ | ..... |
| Adrenal or pituitary problems? | ☐ | ☐ | ..... |

| Kidney and urinary systems | YES | NO | COMMENTS |
|---|---|---|---|
| Kidney (renal) condition? (e.g. only one kidney, dialysis) | ☐ | ☐ | ..... |
| Kidney stones? | ☐ | ☐ | ..... |
| Urinary problems? (e.g. Recurrent infection, bed wetting.) | ☐ | ☐ | ..... |
| Any other kidney or urinary problems? | ☐ | ☐ | ..... |

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

| Liver | YES | NO | COMMENTS |
|---|---|---|---|
| Hepatitis A, B, C, jaundice or liver condition? | ☐ | ☐ | ..... |
| Cirrhosis? | ☐ | ☐ | ..... |
| Gallstones? | ☐ | ☐ | ..... |
| Any other problems? | ☐ | ☐ | ..... |

| Blood disorders | YES | NO | COMMENTS |
|---|---|---|---|
| Blood clots in lungs or legs? (PE, DVT, thrombosis?) | ☐ | ☐ | ..... |
| Bleeding disorder and/or family history (von Willebrands disease/hemophilia) | ☐ | ☐ | ..... |
| Anaemia? | ☐ | ☐ | ..... |
| Previous blood transfusion? If yes, when was the last, and what was the reason? | ☐ | ☐ | ..... |

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

| Bones and joints | YES | NO | COMMENTS |
|---|---|---|---|
| Arthritis/Rheumatoid arthritis? | ☐ | ☐ | ..... |
| Joint replacement or orthopaedic metalware? | ☐ | ☐ | ..... |
| Other issues? | ☐ | ☐ | ..... |

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

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

| Mental health and wellbeing | YES | NO | COMMENTS |
|---|---|---|---|
| Do you suffer from anxiety, depression, PTSD or emotional disturbance or phobias e.g. needles? | ☐ | ☐ | ..... |

| 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? | ☐ | ☐ | ..... |

| 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? | ☐ | ☐ | ..... |
| 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. | ☐ | ☐ | ..... |
| Do you have any dependents? | ☐ | ☐ | ..... |
| Do you have any pets? | ☐ | ☐ | ..... |
| Do you have any problems with daily activities? Can you manage around the house? With or without mobility aids? (e.g. showering, bathing, dressing) | ☐ | ☐ | ..... |
| Do you have stairs at home? | ☐ | ☐ | ..... |
| Have you had a fall in the last 6 months? | ☐ | ☐ | ..... |
| Will someone be taking you home? | ☐ | ☐ | ..... |
| Do you have someone to stay overnight with you when you get home? | ☐ | ☐ | ..... |
| Are you currently using any community support services? If so, please list. | ☐ | ☐ | ..... |
| Do you have any other concerns about your discharge? | ☐ | ☐ | ..... |
| Do you have a disability we should be aware of? | ☐ | ☐ | ..... |

What is the best contact number to reach you on following the first few days after your discharge? .....