

Health Questionnaire



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)

Admission date:

Personal details:

	<small>First name</small>	<small>Middle name</small>	<small>Surname</small>		
Preferred Name		Date of birth	Age	NHI No: <small>If known</small>	
Gender	<small>Known as</small> Male <small>Tāne</small> Female <small>Wahine</small> Another <small>He ira kē anō</small>		Are you: NZ Citizen	Permanent resident	
Ethnicity	Māori	New Zealand European	Samoaan	Cook Island Māori	Tongan
	Niuean	Chinese	Indian	other	<small>such as Dutch, Japanese, Tokelauan. Please state</small>
Email					
Telephone	<small>Home</small>	<small>Work</small>	<small>Mobile</small>		

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

FODMAP

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

If no, which language?

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?