Shore Surgery
SPECIALIST DAY HOSPITAL
Evolution Healthcare

Patent ID Label

Surgeon: ______________________
Procedure: ______________________ Procedure Date: __________

PATIENT DETAILS

Surname: ______________ Mr/Mrs/Miss/Ms/ Dr ______________
First Names: ______________
Address: ______________
Telephone:(Home) __________ (Mobile) __________ (Bus) __________
Email: ______________ Ethnicity: ______________
Date of Birth: ______________ Age: __________
Family GP: ______________
Next of Kin: ______________ Relationship: __________ Phone: __________
Person taking you home: ______________ Relationship: __________ Phone: __________
Have you arranged for someone to stay with you overnight after your Procedure? **Yes** **No**

HEALTH QUESTIONNAIRE PLEASE PROVIDE DETAILS IF YOU ANSWER YES TO ANY QUESTIONS

1. Please list any Allergies or Adverse Reactions to:

	Item			Reaction
Medication related				
Skin related				
Food related				
Other				
Resistant Organisms	MRSA	VRE	ESBL	N/A (Please check)

Patient Medications

It is important you list all medications you are taking, including natural or alternative medications

Medication (drug name)	Dose	Medication (drug name)	Dose

If you are taking Warfarin, what is your most current INR blood result? __________ Date: __________
Have you been instructed to stop any anticoagulant therapy for your procedure? If so how many days ago did you stop taking this medication? ______________

2. Health questions

Height: __________ Weight: __________

Do you have or have you ever had	Yes	No	Comments
Asthma/Shortness of breath			
Sleep Apnoea			
Breathing/Chest problems			
Current cough/cold			
Problems with blood clotting/DVT's, Blood Clots			
Heart problems/ Irregular heart rhythm			
Pacemaker/ Cardiac Stents (please circle)			
Stroke or TIA's (mini strokes)			
High Blood Pressure			
Kidney/Urinary Problems			
Diabetes (if so what type)			
Seizure/Fits or Epilepsy			
Hepatitis/ Tuberculosis			
Rheumatic Fever			
Heartburn/Reflux/ Hiatus hernia			

PTO

	Yes	No	Comments
Depression/Anxiety			
Memory Loss/Confusion			
Any Phobias (Needle, Claustrophobia)			
Joint Replacement Surgery/other Metalware			
Other Prosthesis eg. Breast implants			
Dentures/ Partial Plate/ Dental implants			
Crowns/ Bridges/ Orthodontic fixtures			

Please fill in questions below as this can help us assess and plan your care during your stay with us:

Physical Care	**Yes**	**No**	**Comments**
Do you have any restriction with mobility?			
Do you use any mobility aids eg Walker?			
If in a Wheelchair, are you able to transfer?			
Do you have a tendency to faint?			
Do you have problems with vision?			
Do you wear contact Lenses?			
Do you have problems with hearing?			
Do you wear Hearing Aids/Cochlear Implant?			
Do you need assistance with toileting?			
Do you have delicate skin or unhealed wounds?			

Cultural Care/Dietary needs	**Yes**	**No**	**Comments**
Do you have any cultural/spiritual/whanau needs we should be aware of?			
Do you have any dietary requirements?			

Language	**Yes**	**No**	**Comments**
Is English your first language?			
Will you be using family as an interpreter?			
Would you like us to arrange an interpreter? (there is a cost involved) and advance notice required			

Other	**Yes**	**No**	
Are you a smoker / vaper			If yes, how many per day? ____________
Could you be pregnant? (Women Only)			

Do you have any other Chronic conditions that we have not listed? If so please indicate what these are: ____________

Please list previous hospital admissions for Operations/Procedures:

Year:	**Operation/Procedure:**	**Year:**	**Operation/Procedure:**

Have you had any problems with anaesthetics such as nausea/vomiting, or other problems during or after surgery? **Yes** **No** If yes, please explain problem

Any family history of problems with anaesthetics? **Yes** **No** If yes, please explain issue

Is there anything else we should know that could assist us with your care?

Patient/Guardian Signature: ____________________ **Date:** ____________

Nurses Signature: ____________________ **Date:** ____________