Shore Surgery
SPECIALIST DAY HOSPITAL
Evolution Healthcare

Patent ID Label

Surgeon: _____

Procedure Date: _____ Procedure: _____

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)	☐	☐	
Parkinsons / Deep Brain Stimulator	☐	☐	
High Blood Pressure	☐	☐	
Kidney/Urinary Problems	☐	☐	
Diabetes (if so what type)	☐	☐	
Seizure/Fits or Epilepsy	☐	☐	
Hepatitis/ Tuberculosis	☐	☐	
Rheumatic Fever	☐	☐	
Heartburn/Reflux/ Hiatus hernia	☐	☐	

	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:** _____

SUBMIT