

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:** _____