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 very important that you list ALL medications you are taking, including **weight loss, 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	☐	☐	

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:** _____