Southern Cross Hospitals

Patient health questionnaire

IMPORTANT: Please send this completed form to the Hospital where you will have your procedure/surgery.

Surname (family name): _____ **First name(s):** _____

Date of birth: ____ / ____ / ____
d m y

All questions in this questionnaire are about the person being treated at the Hospital. If you are filling this out for your child, only provide information relating to your child's health.

List procedures/operations/hospital admissions the patient has had (start with the most recent and work backwards).

Procedures/Operations/Hospital Admissions	Year	Hospital

Has the patient ever had or does the patient currently have any of the following?
Please tick a Yes or No. Circle a word where appropriate. Add comments in the spaces provided.

Yes No

- ☐ ☐ Has the patient had an anaesthetic before?
- ☐ ☐ Seizures or abnormal movements after anaesthesia or some medications
- ☐ ☐ Has the patient or any other family member had any problems with an anaesthetic? If answered yes, please explain: _____
- ☐ ☐ Do you have problems opening your mouth (e.g. previous jaw problems, TM joint problems)?
- ☐ ☐ Neck or back problems
- ☐ ☐ Diabetes – diet controlled / requiring tablets
- ☐ ☐ Diabetes – requiring Insulin
  For how long? _____
- ☐ ☐ High blood pressure /Swollen ankles
- ☐ ☐ Palpitations / Irregular heartbeat
- ☐ ☐ Angina / Heart attack / Heart failure / Chest pain
- ☐ ☐ Stroke / TIA (mini strokes)
- ☐ ☐ Epilepsy / Severe headaches / Migraines
- ☐ ☐ Blackouts / Fainting
- ☐ ☐ Asthma / Wheeziness / Shortness of breath
- ☐ ☐ Hospitalised with asthma
- ☐ ☐ Emphysema / Bronchitis / Croup / Lung problems
- ☐ ☐ Obstructive sleep apnoea / Severe snoring (intermittently stopping breathing during sleep)
- ☐ ☐ Tuberculosis / Rheumatic fever / Heart murmur
- ☐ ☐ Heartburn / Acid reflux / Hiatus hernia / Indigestion / Stomach or peptic ulcer
- ☐ ☐ History of irritable bowel / Constipation / Bowel disease
- ☐ ☐ Radiotherapy or Chemotherapy within the last 6 months
- ☐ ☐ Blood clots in legs or lung
- ☐ ☐ Bleeding problems / Anaemia / Bruising
- ☐ ☐ Family history of bleeding problems
- ☐ ☐ Gum or dental health problems
- ☐ ☐ Arthritis. If **YES** which joints?
  _____
  _____

Yes No

- ☐ ☐ Hepatitis A / B / C / Jaundice
- ☐ ☐ Are you a hepatitis carrier?
- ☐ ☐ HIV / AIDS / risk of exposure to HIV
- ☐ ☐ Infection or treatment for the following multi drug resistant organisms MRSA / ESBL / VRE
- ☐ ☐ In the last 6 months have you been a patient or employee in a hospital/s Name of hospital/s _____
  or been a patient or employee in a hospital/s overseas
  Name of hospital/s _____
  Name of country _____
- ☐ ☐ Are you experiencing flu like symptoms or have you been in contact with anyone diagnosed with influenza within the past 7 days?
- ☐ ☐ Have you had a 'head cold', throat/chest infection or bronchitis in the **past 4 weeks**?
- ☐ ☐ Have you had, or been in contact with anyone who has had, vomiting and/or diarrhoea in the past three days (and/or immediately preceding your admission)?
- ☐ ☐ Boils/cuts/sores/scratches or other skin infections/ Septicaemia.
  When? _____
- ☐ ☐ Substance dependency / high use (e.g. drugs, alcohol)

DOES THE PATIENT

- ☐ ☐ Smoke / Used to smoke? How many per day? _____
- ☐ ☐ Drink alcohol? If **YES** how much? _____
- ☐ ☐ Wear dentures / partial plate / have capped teeth / loose teeth
- ☐ ☐ Wear contact lenses / glasses / hearing aid
- ☐ ☐ Have any joint implants / pacemaker / heart valve / other prosthesis / implants / piercings
  _____
- ☐ ☐ Believe you are pregnant? If **YES** state months _____
- ☐ ☐ Suffer from motion sickness: mild / moderate / severe
- ☐ ☐ Have difficulty climbing more than one flight of stairs?
  If **YES**, what restricts this activity? _____

Any other illnesses or conditions?

- ☐ ☐ If **YES** please specify: e.g. Kidney problems, Thyroid disease, Muscular Dystrophy, Parkinson's disease, Alzheimers, Dementia, Previous head injury, Psychiatric/mental illness, Nerve disease, other
  _____

If you have answered YES to any of the above questions, please ensure you provide additional information.

Does the patient take medications or remedies for:

Yes	No		Yes	No	
☐	☐	Blood thinning (e.g. warfarin, aspirin)	☐	☐	Sleeplessness
☐	☐	Heart disease or high blood pressure	☐	☐	Emotional disorders or psychiatric illness
☐	☐	Diabetes or epilepsy	☐	☐	Oral contraceptives
☐	☐	Cortisone (steroids) or anti-inflammatories			

List ALL current medicines, tablets/pills, syrups, ointments, inhalers, injections, herbal remedies, homeopathic, complementary medicines, vitamins and other supplements.

Medications/Remedies	Strength or Dose	Frequency (How often)	For hospital use only

PLEASE BRING ALL THE ABOVE MEDICATIONS/REMEDIES/SUPPLEMENTS IN THEIR ORIGINAL CONTAINERS TO THE HOSPITAL WITH YOU AND IDEALLY A PRINTOUT FROM YOUR GP (OR PHARMACY) THAT INCLUDES DOSAGE REGIME.

Allergies and Sensitivities	Yes	No	Comments
Are you allergic / sensitive to any:			***If YES, please name the items and describe the reaction***
Medications	☐	☐	
Foods	☐	☐	
Plasters /tape/skin preparations			
(e.g. iodine, chlorhexidine)	☐	☐	
Latex	☐	☐	
Other	☐	☐	

IN PREPARATION FOR ADMISSION

Your weight: _____ Kgs Your Height: _____ Your BMI (if known): _____

Does the patient have any special needs? If YES, please provide more details.

Yes	No	
☐	☐	Disability _____
☐	☐	Physical support or aids _____
☐	☐	Religious or spiritual needs _____
☐	☐	Cultural or family/whānau needs _____
☐	☐	Body Parts: If your procedure requires the removal of any body parts (and if this is possible), would you like them returned?
☐	☐	Dietary requirements: Standard ☐ Diabetic ☐ Vegetarian ☐ Food Intolerences ☐ _____ Other ☐ _____
☐	☐	Is there anything we need to know that you prefer not to state here? _____ Please discuss with your Nurse/Medical Specialist when you arrive at the Hospital.
☐	☐	Do you have anxieties, concerns, questions or additional matters you wish to discuss before your surgery with: Surgeon ☐ Anaesthetist ☐ Nurse ☐ Administration ☐
☐	☐	Has the patient had blood taken for self (autologous) transfusion?

Patient / Guardian signature: _____ Date: ____/____/____ (d / m / y)

FOR HOSPITAL USE ONLY

	PRE-ADMISSION Date: / /	ON ADMISSION Date: / /
Responses checked by (name and designation)		
Comments:		