



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

The hospital needs to receive all three forms at least one week prior to your admission. You can hand deliver, fax, scan and email, or post the forms. If you post the forms, please allow 1-2 extra weeks for delivery.

Please complete this questionnaire carefully as the information you supply helps us to provide you with the best and safest possible care during your stay at our hospital. The questionnaire has four sections:

- A** Your general health
- B** In preparation for your hospital admission
- C** In preparation for your procedure
- D** Your current medicines - please return even if blank

Surname <i>(family name)</i>			
First name (s)			
		<i>(Patient label)</i>	
Height	Weight	Surgeon	
_____ metres	_____ kilograms	_____	
		NHI <i>(if known)</i>	_____
		Occupation <i>(optional)</i>	_____

All questions in this questionnaire are about the person being treated at the hospital (the patient). If you are filling this out for the patient, only provide information relating to the patient's health.

Section A Your General Health

A1. MEDICAL PROCEDURE HEALTH ALERTS				
Do any of the following apply to you?				
Q.	Yes	No		If Yes
1	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty climbing more than a flight of stairs	<i>What restricts this activity?</i>
2	<input type="checkbox"/>	<input type="checkbox"/>	Motion sickness	<i>mild / moderate / severe (circle one)</i>
3	<input type="checkbox"/>	<input type="checkbox"/>	Jaw problems <i>(difficulty opening mouth)</i>	<i>Specify:</i>
4	<input type="checkbox"/>	<input type="checkbox"/>	Problems with a previous anaesthetic	<i>Specify:</i>
5	<input type="checkbox"/>	<input type="checkbox"/>	Family history of problems with an anaesthetic	<i>Specify:</i>
6	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker or heart valve replacement	<i>Specify:</i>
7	<input type="checkbox"/>	<input type="checkbox"/>	Joint implants	<i>Specify:</i>
8	<input type="checkbox"/>	<input type="checkbox"/>	Other implants or prostheses	<i>Specify:</i>
9	<input type="checkbox"/>	<input type="checkbox"/>	Substance use or dependency	<i>Specify:</i>
10	<input type="checkbox"/>	<input type="checkbox"/>	Former smoker	<i>When did you quit?</i>
11	<input type="checkbox"/>	<input type="checkbox"/>	Currently on smoking cessation treatment	<i>Specify:</i>
12	<input type="checkbox"/>	<input type="checkbox"/>	Current smoker	<i>How many per day?</i>
13	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant or possibly pregnant	<i>Approximate due date:</i>
14	<input type="checkbox"/>	<input type="checkbox"/>	Breastfeeding	
15	<input type="checkbox"/>	<input type="checkbox"/>	MedicAlert bracelet or necklace wearer	<i>Specify:</i>

Surname (family name)

First name (s)

Hospital Administration only

(Patient label)

Section A Your General Health (continued)

A2. YOUR MEDICAL CONDITIONS		
<p>Do you currently have, or have you previously had, any of the following conditions? If Yes, please circle any applicable options and provide comments in the box below.</p>		
Q.	Yes	No
16	<input type="checkbox"/>	<input type="checkbox"/>
17	<input type="checkbox"/>	<input type="checkbox"/>
18	<input type="checkbox"/>	<input type="checkbox"/>
19	<input type="checkbox"/>	<input type="checkbox"/>
20	<input type="checkbox"/>	<input type="checkbox"/>
21	<input type="checkbox"/>	<input type="checkbox"/>
22	<input type="checkbox"/>	<input type="checkbox"/>
23	<input type="checkbox"/>	<input type="checkbox"/>
24	<input type="checkbox"/>	<input type="checkbox"/>
25	<input type="checkbox"/>	<input type="checkbox"/>
26	<input type="checkbox"/>	<input type="checkbox"/>
27	<input type="checkbox"/>	<input type="checkbox"/>
28	<input type="checkbox"/>	<input type="checkbox"/>
29	<input type="checkbox"/>	<input type="checkbox"/>
30	<input type="checkbox"/>	<input type="checkbox"/>
31	<input type="checkbox"/>	<input type="checkbox"/>
32	<input type="checkbox"/>	<input type="checkbox"/>
33	<input type="checkbox"/>	<input type="checkbox"/>
34	<input type="checkbox"/>	<input type="checkbox"/>
35	<input type="checkbox"/>	<input type="checkbox"/>
36	<input type="checkbox"/>	<input type="checkbox"/>
37	<input type="checkbox"/>	<input type="checkbox"/>
38	<input type="checkbox"/>	<input type="checkbox"/>
39	<input type="checkbox"/>	<input type="checkbox"/>
40	<input type="checkbox"/>	<input type="checkbox"/>
41	<input type="checkbox"/>	<input type="checkbox"/>
42	<input type="checkbox"/>	<input type="checkbox"/>
43	<input type="checkbox"/>	<input type="checkbox"/>
44	<input type="checkbox"/>	<input type="checkbox"/>
45	<input type="checkbox"/>	<input type="checkbox"/>
RE QUESTION		YOUR COMMENT
20	GP says my blood pressure is slightly high, but am not taking any medicine. --- Example ---	

Need more space for your comments? Please continue on a separate sheet and attach it to this page.

Surname (family name)

First name (s)

Hospital Administration only
(Patient label)

Section B In Preparation For Your Hospital Admission

B1. YOUR ALLERGIES, SENSITIVITIES, OR INTOLERANCES

Q. Yes No

46 Are you **allergic to latex**?

47 Do you have **any other allergies, sensitivities or intolerances**?

If **Yes**, please specify and describe the reaction using the box below

	Item	Reaction
Skin-related	Plasters --- Example ---	Rash --- Example ---
Medicine-related		
Food-related		
Other		

B2. YOUR NEEDS AND PREFERENCES

Please answer these questions to help us to tailor how we care for you.

If you answer **Yes** to any of these questions, we may contact you to discuss your specific needs.

Q. Yes No

If Yes

48 Do you have a **disability**?

Specify:

49 Do you have **difficulty understanding English**? Your preferred language:

50 Do you have any **religious or spiritual needs** you would like us to know about? Specify:

51 Do you have any **cultural or family needs** you would like us to know about? Specify:

52 Do you have any **other special needs** you would like us to know about? Specify:

53 If your procedure requires the **removal of body parts**, would you like them returned to you if this is possible?

54 Do you have any **dietary requirements**?

vegetarian vegan diabetic
 gluten free halal dairy free
 breast fed bottle fed
 other _____

55 Do you have any **specific food dislikes**? Specify:
For allergies or intolerances, refer to question 47

Surname (family name)

First name (s)

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(Patient label)

Section C In Preparation For Your Procedure

C1. MEDICAL PROCEDURE HISTORY

Q. Yes No

- 56 Have you previously had any procedures / operations or other hospital admissions?
– If **Yes**, please outline your previous admissions in the table below. If you need more space, please continue on a separate sheet and attach it to this page

Procedure or event

Year

Hospital

Procedure or event	Year	Hospital

C2. ANAESTHESIA CONSIDERATIONS

Q. Yes No

- 57 Have you had an **anaesthetic** before? general spinal epidural unsure
- 58 Do you have any of these **dental features**? upper denture lower denture crown(s) / cap(s)
 partial plate loose or chipped teeth
- 59 Do you **drink alcohol**? How much? _____

C3. PERSONAL ITEMS

Do you use any of these personal items?

Q. Yes No

If **Yes**, use this space to provide details, if needed

- 60 Mobility aids, such as a walking stick or cane
- 61 Glasses or contact lenses
- 62 Hearing aids
- 63 Earrings or other piercing jewellery

C4. BLOOD CLOT AND INFECTION CONSIDERATIONS

Q. Yes No

- 64 Have you completed the pre-admission risk assessment in the **Blood Clots and YOU** brochure?
- 65 Have you recently been on a **long distance flight**? If yes, when? _____
- 66 In the past 3 days, have you had, or been in contact with anyone who has had, **vomiting or diarrhoea**?
- 67 In the past 7 days, have you experienced **flu-like symptoms**, or been in contact with anyone diagnosed with **influenza**?
- 68 In the past 4 weeks, have you had a **head cold, throat or chest infection, or bronchitis**?
- 69 In the past 12 months, have you been a patient or employee in a rest home or hospital in New Zealand or overseas?
If yes, where? _____
- 70 In the past 12 months, have you travelled **overseas**? If yes, where? _____
- 71 Do you have any **boils, cuts, sores, scratches or other skin or urine infections**?

C5. OTHER CONCERNS

Q. Yes No

- 72 Is there anything we need to know that you prefer not to write on this questionnaire?
– If **Yes**, please discuss with your nurse or medical specialist when you arrive at the hospital
- 73 Do you have anxieties, concerns, or questions you wish to discuss before your procedure?
– If **Yes**, who would you like to speak with? your surgeon your anaesthetist
 a nurse one of our admin. staff

