

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. We also need any recent specialist letters. You can hand deliver, fax, photograph or scan (legibly) and email, or post the forms. If you post the forms, please allow for 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

Surname (family name): _____	
First name (s): _____	Hospital Administration only <i>(Patient label)</i>
To support your ongoing care, your discharge information will be sent to your nominated GP. If you do NOT want this, please tick <input type="checkbox"/>	Surgeon _____ NHI (if known) _____ Your Occupation (optional) _____

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 (difficulty opening mouth)	<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 implant or prostheses and metalware	<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"/>	Vaping	<i>How many times per day?</i>
14	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant or possibly pregnant	<i>Approximate due date:</i>
15	<input type="checkbox"/>	<input type="checkbox"/>	Breastfeeding	
16	<input type="checkbox"/>	<input type="checkbox"/>	MediAlert bracelet or necklace wearer	<i>Specify:</i>

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Section A Your General Health (continued)

A2. YOUR MEDICAL CONDITIONS

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.

Q	Yes	No	
17	<input type="checkbox"/>	<input type="checkbox"/>	Breathing conditions: asthma wheeziness shortness of breath bronchitis croup emphysema COPD
18	<input type="checkbox"/>	<input type="checkbox"/>	Sleeping conditions: sleeplessness severe snoring obstructive sleep apnoea CPAP used
19	<input type="checkbox"/>	<input type="checkbox"/>	Heart conditions: palpitations irregular heart beat heart murmur angina heart attack chest pain congestive heart failure rheumatic fever
20	<input type="checkbox"/>	<input type="checkbox"/>	Stroke or Transient Ischaemic Attack (TIA)
21	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure or blood pressure controlled with medication
22	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots: deep vein thrombosis (DVT) pulmonary embolus (PE)
23	<input type="checkbox"/>	<input type="checkbox"/>	Family history of blood clots
24	<input type="checkbox"/>	<input type="checkbox"/>	Blood or bleeding conditions: anaemic bruising
25	<input type="checkbox"/>	<input type="checkbox"/>	Family history of blood or bleeding conditions
26	<input type="checkbox"/>	<input type="checkbox"/>	Stomach and digestive conditions: indigestion heartburn acid reflux hiatus hernia peptic ulcer
27	<input type="checkbox"/>	<input type="checkbox"/>	Bowel conditions: irritable bowel syndrome constipation bowel disease
28	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease: jaundice hepatitis
29	<input type="checkbox"/>	<input type="checkbox"/>	Kidney conditions
30	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes: type 1 type 2 requiring insulin requiring tablets diet controlled
31	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid conditions
32	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's disease
33	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy, seizures, blackouts or fainting
34	<input type="checkbox"/>	<input type="checkbox"/>	Migraines or severe headaches
35	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimers or dementia
36	<input type="checkbox"/>	<input type="checkbox"/>	Mental function conditions: head injury concussion confusion or disorientation
37	<input type="checkbox"/>	<input type="checkbox"/>	Mental health conditions
38	<input type="checkbox"/>	<input type="checkbox"/>	Emotional conditions: anxiety phobia post traumatic stress disorder (PTSD)
39	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis: osteoarthritis rheumatoid other
40	<input type="checkbox"/>	<input type="checkbox"/>	Neck or back conditions
41	<input type="checkbox"/>	<input type="checkbox"/>	Gum or dental health conditions
42	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis (TB)
43	<input type="checkbox"/>	<input type="checkbox"/>	HIV or AIDS
44	<input type="checkbox"/>	<input type="checkbox"/>	Infection or treatment for resistant organisms: MRSA ESBL VRE OTHER
45	<input type="checkbox"/>	<input type="checkbox"/>	Cancer <i>If Yes, please specify and provide details of any recent treatment in the Comments box below</i>
46	<input type="checkbox"/>	<input type="checkbox"/>	Other condition(s) not listed above <i>If Yes, please specify in the Comments box below</i>
RE QUESTION		YOUR COMMENT	
21		<i>GP says my blood pressure is slightly high, but am not taking any medicine.</i>	
		----Example----	

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

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Section B In Preparation For Your Hospital Admission

B1. YOUR ALLERGIES, SENSITIVITIES, OR INTOLERANCES											
Q	Yes No										
47	<input type="checkbox"/> <input type="checkbox"/> Are you allergic to latex ?										
48	<input type="checkbox"/> <input type="checkbox"/> Do you have any other allergies, sensitivities or intolerances ? <i>If Yes, please specify and describe the reaction using the box below</i>										
	<table border="1"><thead><tr><th>Item</th><th>Reaction</th></tr></thead><tbody><tr><td>Skin-related Plasters <i>----Example----</i></td><td>Rash <i>----Example----</i></td></tr><tr><td>Medicine-related</td><td></td></tr><tr><td>Food-related</td><td></td></tr><tr><td>Other</td><td></td></tr></tbody></table>	Item	Reaction	Skin-related Plasters <i>----Example----</i>	Rash <i>----Example----</i>	Medicine-related		Food-related		Other	
Item	Reaction										
Skin-related Plasters <i>----Example----</i>	Rash <i>----Example----</i>										
Medicine-related											
Food-related											
Other											

B2. YOUR NEEDS AND PREFERENCES		
Please answer these questions to help us to tailor how we care for you. <i>If you answer Yes to any of these questions, we may contact you to discuss your specific needs.</i>		
Q	Yes No	If Yes
49	<input type="checkbox"/> <input type="checkbox"/>	Do you have a disability ? <i>Specify:</i>
50	<input type="checkbox"/> <input type="checkbox"/>	Do you have difficulty understanding English ? <i>Your preferred language:</i>
51	<input type="checkbox"/> <input type="checkbox"/>	Do you have any religious or spiritual needs you would like us to know about? <i>Specify:</i>
52	<input type="checkbox"/> <input type="checkbox"/>	Do you have any cultural or family needs you would like us to know about? <i>Specify:</i>
53	<input type="checkbox"/> <input type="checkbox"/>	Do you have any other special needs you would like us to know about? <i>Specify:</i>
54	<input type="checkbox"/> <input type="checkbox"/>	If your procedure requires the removal of body parts , would you like them returned to you if this is possible?
55	<input type="checkbox"/> <input type="checkbox"/>	Do you have any dietary requirements ? <input type="checkbox"/> <i>vegetarian</i> <input type="checkbox"/> <i>vegan</i> <input type="checkbox"/> <i>diabetic</i> <input type="checkbox"/> <i>gluten free</i> <input type="checkbox"/> <i>halal</i> <input type="checkbox"/> <i>dairy free</i> <input type="checkbox"/> <i>bottle fed</i> <input type="checkbox"/> <i>breast fed</i> <input type="checkbox"/> <i>other</i>
56	<input type="checkbox"/> <input type="checkbox"/>	Do you have any specific food dislikes ? <i>For allergies or intolerances, refer to question 48</i> <i>Specify</i>

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Section C In Preparation For Your Procedure

C1. MEDICAL PROCEDURE HISTORY		
Height _____ metres	Weight _____ kilograms	
Q	Yes	No
57	<input type="checkbox"/>	<input type="checkbox"/>
Have you previously had any procedures / operations or other hospital admissions? <i>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</i>		
Procedure or event	Year	Hospital
C2. ANAESTHESIA CONSIDERATIONS		
Q	Yes	No
58	<input type="checkbox"/>	<input type="checkbox"/>
Have you had an anaesthetic before? <input type="checkbox"/> general <input type="checkbox"/> spinal <input type="checkbox"/> epidural <input type="checkbox"/> unsure		
59	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any of these dental features ? <input type="checkbox"/> upper denture <input type="checkbox"/> lower denture <input type="checkbox"/> crown(s) / cap(s) <input type="checkbox"/> partial plate <input type="checkbox"/> loose or chipped teeth		
60	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol ? <i>How much?</i> _____		
C3. PERSONAL ITEMS		
Do you use any of these personal items?		
Q	Yes	No
<i>If Yes, use this space to provide details, if needed</i>		
61	<input type="checkbox"/>	<input type="checkbox"/>
Mobility aids such as a walking stick or cane?		
62	<input type="checkbox"/>	<input type="checkbox"/>
Glasses or contact lenses		
63	<input type="checkbox"/>	<input type="checkbox"/>
Hearing aids		
C4. BLOOD CLOT AND INFECTION CONSIDERATIONS		
Q	Yes	No
64	<input type="checkbox"/>	<input type="checkbox"/>
Have you completed the pre-admission risk assessment in the Blood Clots and YOU brochure?		
65	<input type="checkbox"/>	<input type="checkbox"/>
Have you recently been on a long distance flight ? <i>If Yes, when?</i> _____		
66	<input type="checkbox"/>	<input type="checkbox"/>
If your operation is within the next 3 days: Have you had, or been in contact with anyone who has had vomiting or diarrhoea ?		
67	<input type="checkbox"/>	<input type="checkbox"/>
If your operation is within the next 7 days: Have you experienced flu-like symptoms , or been in contact with anyone diagnosed with influenza ?		
68	<input type="checkbox"/>	<input type="checkbox"/>
If your operation is within the next 4 weeks: Have you had a head cold, throat or chest infection, or bronchitis ?		
69	<input type="checkbox"/>	<input type="checkbox"/>
In the past 12 months, have you travelled overseas ? <i>If Yes, please specify the country:</i> _____		
70	<input type="checkbox"/>	<input type="checkbox"/>
In the past 12 months, have you been a patient or employee in a hospital or rest home in New Zealand or overseas ? <i>If Yes, please specify the country:</i> _____		
71	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any boils, cuts, sores, scratches or other skin infections ? <i>If Yes, specify:</i> _____		
72	<input type="checkbox"/>	<input type="checkbox"/>
Do you have (or have you recently had) a urine infection ? <i>If Yes, specify:</i> _____		
C5. OTHER CONCERNS		
Q	Yes	No
73	<input type="checkbox"/>	<input type="checkbox"/>
Is there anything we need to know that you prefer not to write on this questionnaire? <i>If Yes, please discuss with your nurse or medical specialist when you arrive at the hospital</i>		
74	<input type="checkbox"/>	<input type="checkbox"/>
Do you have anxieties, concerns, or questions you wish to discuss before your procedure? <i>If Yes, who would you like to speak with?</i> <input type="checkbox"/> your surgeon <input type="checkbox"/> your anaesthetist <input type="checkbox"/> a nurse <input type="checkbox"/> one of our admin. staff		

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Section D Your Current Medicines

For your safety, it is extremely important that your doctor and nurses know precisely which medicines you are currently using.

Important instructions.

- List below **all** medicines you currently use, and bring them with you to the hospital in their **original containers**.
- If you are taking any **blood thinning medication or supplements**, check with your surgeon if these need to be stopped prior to your admission.
- If you have a medication card or printout from your GP or pharmacist, please bring it with you to the hospital, as well as completing the list below.

MEDICINE REMINDERS					
Which of the examples below apply to you?					
There are many types of medicine		Medicines come in many forms		Medicines are taken for many common conditions	
<i>prescription medicines</i>	<i>vitamins</i>	<i>tablets</i>	<i>patches</i>	<i>heart disease</i>	<i>infections</i>
<i>herbal medicines</i>	<i>supplements</i>	<i>capsules</i>	<i>suppositories</i>	<i>high blood pressure</i>	<i>diabetes</i>
<i>natural medicines</i>	<i>contraceptives</i>	<i>inhalers</i>	<i>creams</i>	<i>blood thinning</i>	<i>sleeplessness</i>
<i>homeopathic medicines</i>	<i>steroids</i>	<i>drops</i>	<i>injections</i>	<i>dietary deficiencies</i>	<i>epilepsy</i>
<i>over-the-counter medicines</i>		<i>syrups</i>	<i>other liquids</i>	<i>emotional conditions</i>	

D1. YOUR CURRENT MEDICINES			HOSPITAL USE ONLY					
Patient to complete - list all medicines you currently use.			Reconciled: Yes (✓) No (x) Not available (NA)				Comment if No	ON ADMISSION: Date/time last taken
Name of medicine <i>----Example----</i>	Strength	How much you use, and when	Medicine container	Medication card	Patient or whānau/ family	Other (state) eg, 'phoned GP'		
<i>Paracetamol</i>	<i>500mg</i>	<i>2 capsules every 6 hours</i>	-	-	-	-	-	-

If required, please continue on the reverse

This is not a prescription or an instruction to administer medicines

Surname (family name)

First name (s)

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Section D Your Current Medicines (continues)

Continued from reverse.

D1. YOUR CURRENT MEDICINES			HOSPITAL USE ONLY					
Patient to complete - list <u>all</u> medicines you currently use.			Reconciled: Yes (✓) No (x) Not available (NA)					
Name of medicine	Strength	How much you use, and when	Medicine container	Medication card	Patient or whānau/ family	Other (state) eg, 'phoned GP'	Comment if No	ON ADMISSION: Date/time last taken

This is not a prescription or an instruction to administer medicines