NORTH SHORE SURGICAL CENTRE

Patient Health Questionnaire

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 centre admission
C In preparation for your procedure
D Your current medicines

Surname (family name): _____

First name (s): _____

Hospital Administration only
(Patient label)

To support your ongoing care, your discharge information will be sent to your nominated GP. If you do NOT want this, please tick ☐

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	☐	☐	Difficulty climbing more than a flight of stairs	What restricts this activity?
2	☐	☐	Motion sickness	mild ☐ moderate ☐ severe ☐
3	☐	☐	Jaw problems (difficulty opening mouth)	Specify:
4	☐	☐	Problems with a previous anaesthetic	Specify:
5	☐	☐	Family history of problems with an anaesthetic	Specify:
6	☐	☐	Pacemaker or heart valve replacement	Specify:
7	☐	☐	Joint implants	Specify:
8	☐	☐	Other implant or prostheses and metalware	Specify:
9	☐	☐	Substance use or dependency	Specify:
10	☐	☐	Former smoker	When did you quit?
11	☐	☐	Currently on smoking cessation treatment	Specify:
12	☐	☐	Current smoker	How many per day?
13	☐	☐	Vaping	How many times per day?
14	☐	☐	Pregnant or possibly pregnant	Approximate due date:
15	☐	☐	Breastfeeding	
16	☐	☐	MedicAlert bracelet or necklace wearer	Specify:

Surname (family name)

First name (s)

Hospital Administration only
(Patient label)

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	☐	☐	**Breathing conditions:** ☐asthma ☐wheeziness ☐shortness of breath ☐bronchitis ☐croup ☐emphysema
18	☐	☐	COPD **Sleeping conditions:** ☐sleeplessness ☐severe snoring ☐obstructive sleep apnoea ☐CPAP used
19	☐	☐	**Heart conditions:** ☐palpitations ☐irregular heart beat ☐heart murmur ☐angina ☐heart attack ☐chest pain ☐congestive heart failure ☐rheumatic fever
20	☐	☐	**Stroke or Transient Ischaemic Attack (TIA)**
21	☐	☐	**High blood pressure or blood pressure controlled with medication**
22	☐	☐	**Blood clots:** ☐deep vein thrombosis (DVT) ☐pulmonary embolus (PE)
23	☐	☐	**Family history of blood clots**
24	☐	☐	**Blood or bleeding conditions:** ☐ anaemic ☐bruising
25	☐	☐	**Family history of blood or bleeding conditions**
26	☐	☐	**Stomach and digestive conditions:** ☐indigestione ☐ heartburn | acid refluxe ☐ hiatus herniae ☐ peptic ulcer
27	☐	☐	**Bowel conditions:** ☐irritable bowel syndrome ☐constipation ☐bowel disease
28	☐	☐	**Liver disease:** ☐jaundice ☐ hepatitis
29	☐	☐	**Kidney conditions**
30	☐	☐	**Diabetes:** ☐ type 1 ☐ type 2 ☐ requiring insulin ☐ requiring tablets ☐ diet controlled
31	☐	☐	**Thyroid conditions**
32	☐	☐	**Parkinson's disease**
33	☐	☐	**Epilepsy, seizures, blackouts or fainting**
34	☐	☐	**Migraines or severe headaches**
35	☐	☐	**Alzheimers or dementia**
36	☐	☐	**Mental function conditions:** ☐head injury ☐concussion ☐confusion or disorientation
37	☐	☐	**Mental health conditions**
38	☐	☐	**Emotional conditions:** ☐anxiety ☐phobia ☐post traumatic stress disorder (PTSD)
39	☐	☐	**Arthritis:** ☐osteoarthritis ☐rheumatoid ☐other
40	☐	☐	**Neck or back conditions**
41	☐	☐	**Gum or dental health conditions**
42	☐	☐	**Tuberculosis (TB)**
43	☐	☐	**HIV or AIDS**
44	☐	☐	**Infection or treatment for resistant organisms:** ☐MRSA ☐ESBL ☐VRE ☐OTHER
45	☐	☐	**Cancer** If ***Yes,*** please specify and provide details of any recent treatment in the Comments box below
46	☐	☐	**Other condition(s) not listed above** If ***Yes,*** please specify in the Comments box below

RE QUESTION	YOUR COMMENT
21	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	
47	☐	☐	Are you **allergic to latex?**
48	☐	☐	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***
49	☐	☐	Do you have a **disability?**	Specify:
50	☐	☐	Do you have **difficulty understanding English?**	Your preferred language:
51	☐	☐	Do you have any **religious or spiritual needs** you would like us to know about?	Specify:
52	☐	☐	Do you have any **cultural or family needs** you would like us to know about?	Specify:
53	☐	☐	Do you have any **other special needs** you would like us to know about?	Specify:
54	☐	☐	If your procedure requires the **removal of body parts,** would you like them returned to you if this is possible?	
55	☐	☐	Do you have any **dietary requirements?**	☐vegetarian ☐vegan ☐diabetic ☐gluten free ☐halal ☐dairy free ☐other
56	☐	☐	Do you have any **specific food dislikes?** For allergies or intolerances, refer to question ***48***	Specify

Surname (family name)

First name (s)

Hospital Administration only
(Patient label)

Section C In Preparation For Your Procedure

C1. MEDICAL PROCEDURE HISTORY

Height _____ metres **Weight** _____ kilograms

Q	Yes	No	
57	☐	☐	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

C2. ANAESTHESIA CONSIDERATIONS

Q	Yes	No		
58	☐	☐	Have you had an **anaesthetic** before?	☐ general ☐ spinal ☐ epidural ☐ unsure
59	☐	☐	Do you have any of these **dental features?**	☐ upper denture ☐ lower denture ☐ crown(s) / cap(s) ☐ partial plate ☐ loose or chipped teeth
60	☐	☐	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
61	☐	☐	Mobility aids such as a walking stick or cane?	
62	☐	☐	Glasses or contact lenses	
63	☐	☐	Hearing aids	

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	☐	☐	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	☐	☐	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	☐	☐	If your operation is within the next 4 weeks: Have you had a **head cold, throat or chest infection, or bronchitis?**
69	☐	☐	In the past 12 months, have you **travelled overseas?** If **Yes**, please specify the country: _____
70	☐	☐	In the past 12 months, have you been a patient or employee in a hospital or rest home in **New Zealand or overseas?** If **Yes**, please specify the country: _____
71	☐	☐	Do you have any **boils, cuts, sores, scratches or other skin infections?** If **Yes**, specify: _____
72	☐	☐	Do you have (or have you recently had) a **urine infection?** If **Yes**, specify: _____

C5. OTHER CONCERNS

Q	Yes	No		
73	☐	☐	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	
74	☐	☐	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*

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

Hospital Administration only
(Patient label)

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.

1. List below all medicines you currently use, and bring them with you to the centre in their original containers.
2. If you are taking any **blood thinning medication or supplements**, check with your surgeon if these need to be stopped prior to your admission .
3. If you have a medication card or printout from your GP or pharmacist, please bring it with you to the centre, 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**	
prescription medicines	*vitamins*	*tablets*	*patches*	*heart disease*	*infections*
herbal medicines	*supplements*	*capsules*	*suppositories*	*high blood pressure*	*diabetes*
natural medicines	*contraceptives*	*inhalers*	*creams*	*blood thinning*	*sleeplessness*
homeopathic medicines	*steroids*	*drops*	*injections*	*dietary deficiencies*	*epilepsy*
over-the-counter medicines		*syrups*	*other liquids*	*emotional conditions*	

D1. YOUR CURRENT MEDICINES			**CENTRE USE ONLY**					
Patient to complete - list all medicines you currently use.			**Reconciled:** Yes (x) | No (**x**) | Not available (**NA**)					
Name of medicine ----Example----	**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*
Paracetomol	500mg	2 capsules every 6 hours	-	-	-	-	-	-

If required, please continue on the reverse

This is not a prescription or an instruction to administer medicines

Surname (family name)

First name (s)

Hospital Administration only
(Patient label)

Section D Your Current Medicines (continued)

Continued from reverse.

D1. YOUR CURRENT MEDICINES			CENTRE USE ONLY					
Patient to complete - list all medicines you currently use.			**Reconciled:** Yes (x) | 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