Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

ADULT HEALTH QUESTIONNAIRE

PATIENT BRADMA LABEL

Hospital: ______
NHI: ______ Surname: ______
Given Names: ______
Address: ______
D.O.B.: ______ Sex: ______

Today's Date: ______	Proposed surgery/procedure: ______	
How tall are you? ______		How much do you weigh? ______
Are you completing this questionnaire on behalf of someone else?	Y	N	If so please state relationship. ______

MEDICAL CONDITIONS

Do you have or have you ever had any of the following medical conditions? Please indicate by circling the Y (Yes) or N (No)			**If yes or not certain please comment in the boxes below.**
High blood pressure?	Y	N	
Heart conditions (e.g. heart murmur, valve disease, chest pain or discomfort, angina, palpitations or irregular heart beat)	Y	N	
Heart/Lung surgery?	Y	N	
Implanted cardiac defibrillator (ICD) or Pacemaker?	Y	N	When it was last checked? ______
Shortness of breath at night?	Y	N	
Blackouts or fainting?	Y	N	
Swollen ankles?	Y	N	
Breathing difficulties (e.g. asthma, emphysema, C.O.R.D., bronchitis?	Y	N	*(Please bring peak flow recordings with you if available)*
Have you taken steroids for your breathing difficulty in the past 5 years?	Y	N	When was the last course? ______
Sleep apnoea (or have you been told you stop breathing while asleep)?	Y	N	
Sleepiness during the day?	Y	N	
Kidney (Renal) condition?	Y	N	
Diabetes? *Please tick which type* Type 1 ☐ Type 2 ☐	Y	N	Do you currently use: (please circle) Insulin Tablets Diet control *(Please bring blood sugar recordings with you if available)*
Stroke (Cerebrovascular accident or CVA)?	Y	N	
Sudden loss of vision, speech or movement?	Y	N	
Blood clots in lungs or legs or a bleeding disorder, (PE, DVT, thrombosis)?	Y	N	
Heartburn/reflux of acid/hiatus hernia?	Y	N	
Thyroid problems?	Y	N	
Dementia? (e.g. Alzheimers, forgetfulness)	Y	N	

Do you have or have you ever had any of the following medical conditions? Please indicate by circling Y (Yes) or N (No)			If yes or not certain please comment in the boxes below.
Epilepsy?	Y	N	How often do you have seizures? ___________ When was your last seizure? ___________
Arthritis?	Y	N	
Joint replacement or orthopaedic metalware?	Y	N	What type?
Muscle disease?	Y	N	
Jaw, neck, back problems?	Y	N	
Hepatitis A, B, C, jaundice or liver condition?	Y	N	
Transmittable disease (such as MRSA, 'golden staph', boils, skin or other infection, septicaemia, HIV, VRSA)?	Y	N	
Tuberculosis (TB)?	Y	N	Have you had or are you on treatment for this?
Are there any conditions that run in your family? (e.g. malignant hyperthermia, thalaessaemia, muscular dystrophy)?	Y	N	
Anaemia?	Y	N	
Previous blood transfusion?	Y	N	When was the last and what was the reason?
Phobias (e.g. claustrophobia, anxiety attacks)?	Y	N	
Travelled overseas in the last 6 months?	Y	N	Were you hospitalised?
A visual or hearing impairment	Y	N	
Do you have any current pain problems	Y	N	What is the location of the pain?
Is there any other relevant medical condition that you need to tell us about?			

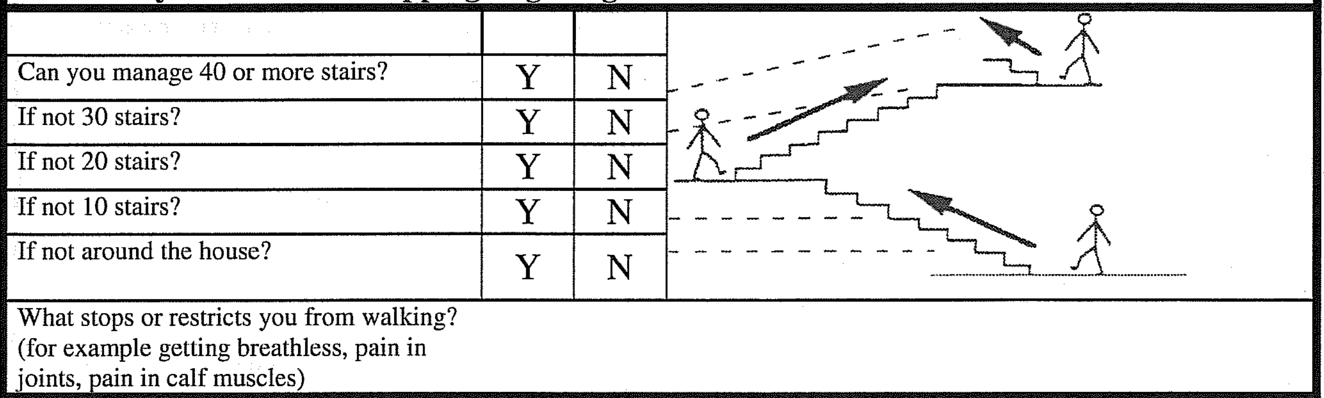
ALLERGIES

Allergies or reactions to medicines (sticking plasters , food, paint, latex / rubber products or x-ray dye)?	Y	N	Please describe what happens to you.

HEALTH PROFESSIONALS

List the name(s) of the hospital/clinic/doctors/surgeons/nurses you see		
Doctor's name	Reason you see this doctor	Date of last visit

FITNESS AND LIFESTYLE



What can you do without stopping or getting breathless?		
Can you manage 40 or more stairs?	Y	N
If not 30 stairs?	Y	N
If not 20 stairs?	Y	N
If not 10 stairs?	Y	N
If not around the house?	Y	N
What stops or restricts you from walking? (for example getting breathless, pain in joints, pain in calf muscles)		

Do you smoke?	Y	N	How many per day?
Have you ever smoked?	Y	N	If so when did you stop?
Do you drink alcohol regularly?	Y	N	How much per week?
Are you or do you think you may be pregnant?	Y	N	If yes – how many weeks?

MEDICATIONS

Please list all medications you currently take including the dose and how often you take the medication in a day (this includes; tablets, injections, contraceptive pills, inhalers, puffers, eye drops, patches, etc). Please also include over-the-counter and any complementary, herbal, homeopathic or other alternative therapies.

Name of Medication/Therapy	How much?	How often each day? (Breakfast, lunch, tea)

PREVIOUS SURGERY/ ANAESTHESIA

Have you ever had surgery or been admitted to hospital before?	Y	N	Including day surgery – If yes, when, what for and what hospital was that in?

Operation / Illness	Year	Hospital

ANAESTHESIA RELATED ISSUES

If yes or not certain please comment in the boxes below.			
Have you had any problems while under an anaesthetic?	Y	N	(e.g. slow to wake, nausea and vomiting, post surgery confusion, agitation)
Has any blood relative had problems while under an anaesthetic?	Y	N	
Have you attended a pre-anaesthesia assessment before?	Y	N	When was the last time?
If a phone call is required for further information relating to this questionnaire, please provide details on how we can contact you.			**Your contact numbers** Home: ( )________________ Work: ( )________________ Mobile: ( )________________ Email: ________________
Are you happy for us to leave a message?	Y	N	With person? ☐ ____________ On answer phone? ☐ ____________
When is the best time for you to receive telephone calls from staff?	Time: ________________		
Is there anything in particular you would like to discuss?			

DISCHARGE PLANNING

Do you require any physical support or aids?	Y	N	If so what?
Do you live alone?	Y	N	
Do you have any problems with daily activities?	Y	N	(e.g. showering, bathing, dressing)
Who will be taking you home?			
Do you have someone to stay overnight with you when you get home?	Y	N	
Are you currently using any community support services?	Y	N	If so please list.
Do you speak and understand English?	Y	N	If not what is your first language? ________________

DECLARATION

The above health information is a true and accurate account of my health status

Patient's signature: ________________________ Date: ________________

C&C DHB use only:

Health questionnaire assessed by (name and position). Name: ________________________

Position: ________________ Date________________

PRE-ANAESTHESIA REQUIREMENTS

☐ Pre-Op Phone Call

☐ Nurse Clinician Clinic

☐ Anaesthetist General Clinic

☐ Paediatric Specialist Clinic

☐ Pre-anaesthesia clinic not required