Adult Health Questionnaire

Surname: ……………………NHI: ………………………
First Names: ……………………………………………
Date of Birth: …………/…………/…………
Sex: ………………
PLACE PATIENT ID HERE

PATIENT DETAILS

Today's date: / /	Your height:
BMI:	Your weight:

Proposed surgery / procedure:

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?	Yes:	No:	If yes, please give person's name:
With a person?	Yes:	No:	
On answer phone?	Yes:	No:	
When is the best time for you to receive telephone calls from staff?			

CAPITAL & COAST DHB USE ONLY

Health questionnaire assessed by (name and position).

Name:

Position:

Date: / /

Pre-anaesthesia Requirements

Nurse telephone call	Routine	Complex	High risk	Paediatric specialist

MEDICAL CONDITIONS

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

Continued overleaf

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

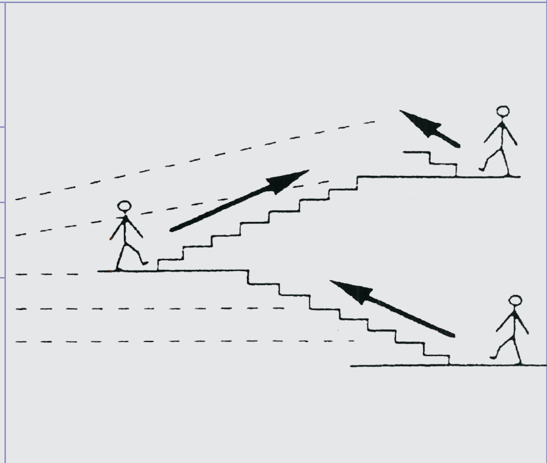
HEALTH PROFESSIONALS

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?

40 stairs:		30 stairs:	
20 stairs:		10 stairs:	
Can you manage around the house?	Yes:	No:	
Has this changed in the last 6 months?	Yes:	No:	
If yes, what could you do without stopping or getting breathless 6 months ago?			
40 stairs:		30 stairs:	
20 stairs:		10 stairs:	



What stops or restricts you from walking now? (e.g. getting breathless, pain in joints, pain in calf muscles)	

Do you smoke?	Yes:	No:	How many per day?
Have you ever smoked?	Yes:	No:	If so when did you stop?
Do you drink alcohol regularly?	Yes:	No:	How much per week?
Are you or do you think you may be pregnant?	Yes:	No:	If yes – how many weeks?

ALLERGIES

Allergies or reactions to medicines (sticking plasters, food, paint, latex / rubber products or x-ray dye)?	Yes:	No:	Please describe what happens to you:

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?	Yes:	No:	**Including day surgery.** ***If yes, when, what for and what hospital was that in?***

Operation / Illness:	Year:	Hospital:

ANAESTHESIA RELATED ISSUES

Do you have or have you ever had any of the following? ***Please tick "Yes" or "No".***			***If yes, or not certain, please comment in the boxes below.***
Have you had any problems while under an anaesthetic?	Yes:	No:	(e.g. slow to wake, nausea and vomiting, post surgery confusion, agitation)
Has any blood relative had problems while under an anaesthetic?	Yes:	No:	
Have you attended a pre-anaesthesia assessment before?	Yes:	No:	When was the last time?

DISCHARGE PLANNING

Do any of the following apply to you? ***Please tick "Yes" or "No".***			***If yes, or not certain, please comment in the boxes below.***
Do you require any physical support or aids?	Yes:	No:	If so what?
Do you live alone?	Yes:	No:	
Do you have any problems with daily activities?	Yes:	No:	(e.g. showering, bathing, dressing)
Who will be taking you home?	Yes:	No:	
Do you have someone to stay overnight with you when you get home?	Yes:	No:	
Are you currently using any community support services?	Yes:	No:	If so please list:
Do you speak and understand English?	Yes:	No:	If not what is your first language?

Is there anything in particular you would like to discuss?

PATIENT DECLARATION

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

Patient's signature: Date: / /