Health Questionnaire

Please complete both sides of this questionnaire and post, or email to Churchill Hospital as early as possible so that we are able to meet all your needs and plan for your admission.

Churchill Hospital

P 03 520 9653, PO Box 351 Blenheim 7240
E admin@churchillhospital.co.nz

Surname: _____ First name(s): _____

Address: _____

Home Phone: _____ Work/Mobile: _____

Date of birth: _____ Email: _____

GP: _____ Ethnicity: _____

Contact Person: _____ Contact Person's Daytime Ph: _____

Date of Surgery (if known): _____ Surgeon: _____

Surgery/Procedure: _____

Please indicate yes or no by ticking the box. Do you have, or have you ever had:

High blood pressure	☐ Yes	☐ No	Kidney problems	☐ Yes	☐ No
Palpitations / Irregular heartbeat	☐ Yes	☐ No	Liver problems	☐ Yes	☐ No
Angina / Chest pain	☐ Yes	☐ No	Hepatitis A, B or C / Jaundice	☐ Yes	☐ No
Heart attack	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Heart failure	☐ Yes	☐ No	Thyroid disease	☐ Yes	☐ No
Heart murmer	☐ Yes	☐ No	HIV or AIDS	☐ Yes	☐ No
Heart valve / Pacemaker / Stent	☐ Yes	☐ No	MRSA, VRE, ESBL (infections)	☐ Yes	☐ No
Rheumatic fever	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hiatus hernia / Acid reflux	☐ Yes	☐ No
Emphysema / Bronchitis	☐ Yes	☐ No	Stomach ulcer	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No	Blood clots in legs or lungs	☐ Yes	☐ No
Obstructive sleep apneoa / CPAP	☐ Yes	☐ No	Bleeding problems / bruise easily	☐ Yes	☐ No
Persistent cough	☐ Yes	☐ No	Blood clotting disorder	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Anaemia	☐ Yes	☐ No
Stroke / TIA	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Epilepsy / Blackouts	☐ Yes	☐ No	How is your diabetes managed? Insulin ☐ Medication ☐ Diet ☐		

Have you ever had an anaesthetic?	☐ Yes	☐ No	
Do you, or do any of your family have problems with anaesthetic?	☐ Yes	☐ No	If yes, please describe: _____
Do you suffer from motion sickness?	☐ Yes	☐ No	_____
Do you have problems opening your mouth? i.e. Jaw problems	☐ Yes	☐ No	
Do you have, or is there a family history of malignant hyperthermia?	☐ Yes	☐ No	

Your Height _____ Your Weight _____ ***(Please provide, it is important for your anaesthetic)***

Do you Smoke?	☐ Yes	☐ No	How many per day? _____
Would you like to access the Quit Programme?	☐ Yes	☐ No	
Are you an ex-smoker?	☐ Yes	☐ No	When did you stop? _____
Do you drink alcohol?	☐ Yes	☐ No	How many drinks/day? _____ per/week? _____
Do you wear dentures	☐ Yes	☐ No	
Do you have: *caps* or *crowns*, *loose teeth (please circle)*	☐ Yes	☐ No	
Do you think you are pregnant?	☐ Yes	☐ No	How many months? _____
Do you have joint implants or metalware?	☐ Yes	☐ No	Where? _____
Do you live alone?	☐ Yes	☐ No	
Do you become short of breath undertaking day to day activities?	☐ Yes	☐ No	
Have you been in an overseas hospital, in the last 12 months?	☐ Yes	☐ No	Where? _____
What countries have you visited in the last 12 months?	_____		
Do you have an emotional or psychiatric illness?	☐ Yes	☐ No	
Any other condition not covered that you feel we should know about?	☐ Yes	☐ No	Please describe: _____

Please complete the other side →

Churchill Hospital

P 03 520 9653, PO Box 351 Blenheim 7240
E admin@churchillhospital.co.nz

Please list the most recent previous operations or procedures you have had:

Operation / Procedure	Year	Hospital
1.		
2.		
3.		
4.		

Are you taking any prescribed medications?

Yes ☐ No ☐

You must ask your GP or pharmacist for a list of all your current medications and provide a copy to Churchill Hospital.

(A hand written list is not permissible, as it does not meet the medication safety requirements.)

Please ensure you bring all medications with you on admission in their original containers with contents clearly defined.

Please list any vitamins, herbal medications or other non-prescribed remedies:

Please list any allergies to drugs, food or other substances and your reaction:

Allergy	Reaction

Please specify any special requirements:

Special dietary requirements?	☐ Yes	☐ No	Please state:
Physical support/needs? (i.e. Hearing, vision, mobility)	☐ Yes	☐ No	
Do you have special religious/spiritual needs?	☐ Yes	☐ No	
Do you have special cultural/family needs?	☐ Yes	☐ No	
Do you wish to access a Maori health worker?	☐ Yes	☐ No	
Do you have wishes regarding the return of body parts?	☐ Yes	☐ No	
Do you currently receive home help?	☐ Yes	☐ No	
Do you require an Interpreter?	☐ Yes	☐ No	If yes, preferred language:
Are there any other special needs that we should know about?	☐ Yes	☐ No	Please state:

Please check you have completed all sections of this form.
Have you attached a list of your medications?

Signature of Patient *(parent / guardian)*: _____ Date: _____

Please note: If a pre-admission is required, Churchill Private Hospital Trust will contact you approximately one week prior to your admission date. Churchill Private Hospital Trust has a smoke-free policy that includes the buildings and grounds.
Thank you for completing this health questionnaire.

Office Use only BMI= Pre admit ☐ Yes ☐ No

Responses Checked By: Date Checked By RN: ☐