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

Date of Surgery: _____

Surgeon: _____

Surgery / Procedure:

_____

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AFFIX PATIENT LABEL HERE

Patient Details *(please circle)*

Title Mr Mrs Ms Master Miss

NHI: _____

Gender Male Female Other

Surname: _____ First name(s): _____

Preferred name: _____ Date of birth: _____

Physical Address: _____

Postal Address: _____

Home Phone: _____ Work Phone: _____

Mobile: _____ Email: _____

Which Ethnic group(s) do you belong to?

NZ/European Maori Pacific *(Please specify)* _____

Asian *(Please specify)* _____ Other *(Please specify)* _____

NZ Resident? Yes No

General Practitioner

Practice: _____

GP: _____ Phone: _____

Usual Pharmacy: _____ Phone: _____

Emergency Contact

This is the person we will contact in case of an emergency. Please make sure this person is aware you are having an operation.

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____

Discharge Contact *(Only complete if different from above)*

This is the person we will contact after the operation and who will collect you from the hospital. Please make sure this person is aware you are having an operation.

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____

Do you have special dietary requirements? _____

Do you have special religious or spiritual needs? _____

Please specify any cultural requirements you have that will help us individualise your care: _____

_____

_____

Please continue inside →

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Please indicate yes or no by ticking the box.

Would you like support from Maori Health Services te Waka Hauora during your stay? ..... 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 .....
Do you smoke? ..... Yes No How many/day? _____
Do you vape? ..... Yes No How many/day? _____
Do you use recreational drugs? ..... Yes No .....
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 per day?____ per week?____
Do you have: *(Please circle)* Yes No

Crowns Capped teeth Loose teeth Dentures: Upper Lower Partial plate

When was your last dental check? *(Applies to joint replacement patients only)* _____
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 any NZ or overseas hospital, in the last 12 months? Yes No .....
What countries have you visited in the last 12 months? _____

Do you have any physical support/needs? ..... Yes No .....
ie: Hearing, vision, mobility issues?
Are there any other special needs that we should know about? ... Yes No _____

Height _____ ***cm*** **Weight** _____ ***kg***
Please provide as this is important for your anaesthetic.

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BMI _____

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

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

Do you have any other medical condition not covered that you feel we should know about? Yes No
(Please specify) _____

Please complete the next page →

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AFFIX PATIENT LABEL HERE

Have you had previous surgery or hospital admissions? Yes No If yes, please provide details below:

Operation / Procedure	Year	Hospital

Do you or any of your family have problems with anaesthetic? Yes No
If yes, please describe:

(If yes please circle)

Do you suffer from Motion sickness? Yes No Mild Moderate Severe
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

Have you ever had any allergic reaction to medications, latex, iodine, plasters, food, or any other substance? Yes No
If yes, please describe the reaction/s:

Do you regularly take any medication?

Yes **No**

You must obtain a printed list of all your medications from your GP or Pharmacist *(this is required by law)* **and send it into Churchill Hospital with your Health Questionnaire, prior to admission. A hand written list is not acceptable.**

- ***NON prescription medications you regularly take e.g. homeopathic, vitamins etc. will be discussed with you on admission.***
- ***Bring all medication with you on admission in their original containers with the contents clearly identified.***
- ***Continue taking all prescription medications prior to admission unless advised otherwise.***

Are you taking any Supplementary Medications? Yes No
If yes, please list below:

Name of supplementary medicine	Strength	How much you use	When you take them

Please complete declaration ↓

Declaration

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

Signature of Patient *(Parent / Guardian)*: _____ Date: _____

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

Office Use only BMI= Pre admit Yes No
Responses Checked By: Date Checked By RN: