Patient health questionnaire

Allevia Hospitals

Please return this form **at least one week** prior to your operation/procedure date

My operation/procedure is booked at: ☐ Allevia Hospital Epsom ☐ Allevia Hospital Ascot

Dear Patient

The information requested in this form will help us assess your needs and plan your care for your booked admission to Allevia Hospitals. All information will be treated in strict confidence.

When answering the questions, please do not write 'see my notes' or words to the same effect because we will not have all your clinical notes. Please answer as accurately as possible.

Please answer **all questions** on each page even if you think they are irrelevant to your circumstances.

Please bring any relevant X-rays/CT/MRI scans (CD discs) with you along with any mobility aids, CPAP machines etc. to the hospital. If you develop any coughs, colds, infections or wounds before your admission, contact your specialist prior to your admission.

Please ensure you are aware of when you should stop eating and drinking prior to your admission. Your specialist should advise you of these times. Please note this includes chewing gum, lollies, sugar etc. If you do not follow these instructions, you risk having your surgery cancelled.

We look forward to helping you prepare for your operation.

Admissions Unit nurses

Patient details

Legal name: _____ **Date of birth:** (dd/mm/yy) / /

Planned procedure: _____

Date of surgery: / / **Best contact phone number:** ( )

Height: _____ cm **Weight:** _____ kg This information is important. **Do not leave this blank.** If you do not know, an estimate is acceptable.

Do you have any allergies? Yes ☐ No ☐

Are you allergic/sensitive to any: (circle which and describe below)

Medications **Foods** **Latex** **Plasters/tape/skin preparations** (e.g. iodine, chlorhexidine) **Other**

Substance	Reaction

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Medications

Do you regularly use any medications? Yes ☐ No ☐ If '**yes**', please provide details in the table below.

Please list **ALL** medicines – tablets, inhalers, patches etc. prescribed by your doctor **or over the counter** (include any herbal or natural remedies). **If you require more space, attach an additional sheet**.

Name of medication	Dose	Frequency

Please bring all your medications, in original packets, with you to hospital.

Do you take any of the below blood thinning medications? Yes ☐ No ☐

☐ Clopidogrel (Plavix) ☐ Warfarin (Marevan or Coumadin) ☐ Dabigatran (Pradaxa) ☐ Rivaroxaban (Xarelto)
☐ Apixaban (Eliquis) ☐ Ticagrelor (Brillinta) ☐ Dipyridamole (Pytazen) ☐ Prasugrel (Effient)
☐ Enoxaparin (Clexane) ☐ None of these

Has your specialist advised you to withhold this medication prior to your surgery? Yes ☐ No ☐

If '**yes**', please provide details:

Have you been taking opioids (i.e. morphine, oxycodone) for a period of more than 3 months? Yes ☐ No ☐

If '**yes**', which medicine/s:

Do you take any medicines to treat opioid dependence (i.e. methadone, Suboxone®), alcohol dependence (i.e. naltrexone) or to aid in smoking cessation or weight loss (i.e. Contrave®, liraglutide, semaglutide)? Yes ☐ No ☐

If '**yes**', which medicine/s:

Have you ever had: ☐ MRSA ☐ ESBL ☐ VRE ☐ CRE ☐ Other multi-resistant organisms
☐ None of these Approximate date:

Have you been a patient or worked in an **overseas** hospital in the last 12 months? Yes ☐ No ☐

If '**yes**', which country: Approximate date:

Have you been a patient for one or more nights in any **New Zealand** hospital in the last 12 months? Yes ☐ No ☐

If '**yes**', when: Hospital/s:

Have you been a resident in a rest home or long-term care facility (e.g. rehab facility) in the last 12 months (excludes independent living in a retirement village)? Yes ☐ No ☐

Have you lived or travelled outside of New Zealand or Australia in the last 12 months? Yes ☐ No ☐

If '**yes**', which countries: Approx. date of return or arrival to New Zealand:

Do you have a history of CJD or other prion disease in your family (including 1st & 2nd degree relatives)? Yes ☐ No ☐

If '**yes**', please provide details:

Have you received human growth hormone or gonadotropin treatment prior to 1986? Yes ☐ No ☐

If '**yes**', please provide details: Date:

Have you received a dura mater graft before 1990? Yes ☐ No ☐

If '**yes**', please provide details: Date:

Have you ever had previous surgery? Yes ☐ No ☐

Please list **all** previous admissions to hospital for surgical procedures. Please include where and when (estimate if unsure).
If you require more space, attach an additional sheet.

Previous surgery	Hospital	Year

Have you suffered post-op nausea and vomiting with recent surgeries? Yes ☐ No ☐

If '**yes**', please provide details:

Have you or a blood relative ever had any problems during or after anaesthesia?
e.g. malignant hyperthermia, muscular dystrophy Yes ☐ No ☐

If '**yes**', please provide details:

Problems opening your mouth? Yes ☐ No ☐

If '**yes**', please provide details:

Are you or could you be pregnant? Yes ☐ No ☐

If '**yes**', please provide details:

Do you have, or have you ever had, any of the following?

High blood pressure controlled with medication: Yes ☐ No ☐

If '**yes**', please provide details:

Heart attack: Yes ☐ No ☐

If '**yes**', please provide details: Date:

Heart murmur: Yes ☐ No ☐

If '**yes**', please provide details:

Artificial heart valve: Yes ☐ No ☐

If '**yes**', please provide details: Date:

Chest pains/angina: Yes ☐ No ☐

If '**yes**', please provide details: Date:

Coronary angiogram or stents in the heart: Yes ☐ No ☐

If '**yes**', please provide details: Date:

Rheumatic fever: Yes ☐ No ☐

If '**yes**', please provide details: Date:

Atrial fibrillation/palpitations/arrhythmias: Yes ☐ No ☐

If '**yes**', please provide details:

Cardiac devices e.g. pacemaker, ICD: Yes ☐ No ☐

If '**yes**', please provide details:

Have you seen a heart specialist doctor/s in the last 5 years: Yes ☐ No ☐

If '**yes**', please specify: When did you last see them:

COPD/emphysema: Yes ☐ No ☐

If '**yes**', please provide details:

Asthma: Yes ☐ No ☐

If '**yes**', please provide details:

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Persistent cough: Yes ☐ No ☐
If '**yes**', please provide details:

Shortness of breath: Yes ☐ No ☐
If '**yes**', please provide details:

Obstructive sleep apnoea: Yes ☐ No ☐
If '**yes**', do you use a CPAP or other sleep apnoea device? Yes ☐ No ☐

Have you had a 'headcold', throat/chest infection or bronchitis in the 4 weeks prior to admission? Yes ☐ No ☐
If '**yes**', please provide details: Date:

Stroke/TIA: Yes ☐ No ☐
If '**yes**', please provide details: Date:

Anaemia: Yes ☐ No ☐
If '**yes**', please provide details:

Bleeding disorders: Yes ☐ No ☐
If '**yes**', please provide details:

Blood clots in legs or lungs (DVT/Pulmonary embolism): Yes ☐ No ☐
If '**yes**', please provide details: Date:

Epilepsy/seizures: Yes ☐ No ☐
If '**yes**', please provide details: Last seizure date:

Blackouts/fainting: Yes ☐ No ☐
If '**yes**', please provide details: Date:

Diabetes: Yes ☐ No ☐

☐ Type 1 ☐ Type 2

If '**yes**', do you take any of the following medications?

☐ Insulin ☐ Empagliflozin (Jardiance) ☐ Empagliflozin + Metformin (Jardiamet) ☐ Dapagliflozin (Forxiga)
☐ Canagliflozin (Invokana) ☐ Dapagliflozin + Metformin (Xigduo XR) ☐ None of these

Has your specialist advised you to withhold this medication prior to your surgery? Yes ☐ No ☐
If '**yes**', please provide details:

Kidney problems: Yes ☐ No ☐
If '**yes**', please provide details:

Hepatitis: Yes ☐ No ☐
If '**yes**', please provide details:

Liver cirrhosis: Yes ☐ No ☐
If '**yes**', please provide details:

HIV/AIDS: Yes ☐ No ☐
If '**yes**', please provide details:

Tuberculosis: Yes ☐ No ☐
If '**yes**', please provide details: Date:

Mental illness: Yes ☐ No ☐
If '**yes**', please provide details:

Anxiety: Yes ☐ No ☐
If '**yes**', please provide details:

Depression: Yes ☐ No ☐
If '**yes**', please provide details:

Dementia/Alzheimer's: Yes ☐ No ☐
If '**yes**', please provide details:

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Arthritis: Yes ☐ No ☐

If '**yes**', please provide details:

Joint implants or metalware: Yes ☐ No ☐

If '**yes**', please provide details:

Do you currently use:

Crutches: Yes ☐ No ☐

If '**yes**', please provide details:

Walking stick: Yes ☐ No ☐

If '**yes**', please provide details:

Walker or frame: Yes ☐ No ☐

If '**yes**', please provide details:

Wheelchair: Yes ☐ No ☐

Do you require any assistance to transfer? Yes ☐ No ☐

If '**yes**', please provide details:

Have you had any falls within the last 6 months? Yes ☐ No ☐

If '**yes**', please provide details: Date:

Heartburn/reflux: Yes ☐ No ☐

If '**yes**', please provide details:

Bowel conditions: Yes ☐ No ☐

If '**yes**', please provide details:

Bladder conditions: Yes ☐ No ☐

If '**yes**', please provide details:

Current skin problems e.g. ulcers, wounds, eczema, boils: Yes ☐ No ☐

If '**yes**', please provide details:

Do you have difficulty with your sight, hearing or communication? Yes ☐ No ☐

If '**yes**', please provide details:

Do you have any other medical conditions not already covered, or is there anything else we should know about you e.g. Parkinson's, muscle/nerve disease? Yes ☐ No ☐

If '**yes**', please provide details:

Do you or have you ever smoked? Yes ☐ No ☐

If '**yes**', how much? For how long? When did you give up?

Do you or have you ever vaped? Yes ☐ No ☐

How often did you have a drink containing alcohol in the past year?

☐ Never ☐ Monthly or less ☐ 2–4 times a month ☐ 2–3 times a week ☐ 4 or more times a week

How many standard drinks containing alcohol do you have on a typical day when you are drinking?

☐ 1–2 ☐ 3–4 ☐ 5–6 ☐ 7–9 ☐ 10 or more

How often do you have 6 or more drinks on one occasion?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily/almost daily

Do you use recreational drugs? Yes ☐ No ☐

If '**yes**', what type? How often?

Do you have any special dietary requirements? Yes ☐ No ☐

If '**yes**', please provide details:

Do you have any religious beliefs/practices or cultural needs we should be aware of? Yes ☐ No ☐

If '**yes**', please provide details:

Discharge planning

Being prepared for your discharge is just as important as being prepared for your admission. As part of your discharge plan we will anticipate the day of discharge prior to your arrival at the hospital. This will relieve your anxiety and help you be ready for your discharge home.

You will need someone to stay with you for 24–48 hours after discharge.
This may be longer depending on your surgery.

Please complete the section below so we can see what care and support you will need to ensure a safe and speedy recovery.

Carer support

Current living arrangements?

☐ Live alone ☐ Live with others i.e. partner/children

Who will be caring for **you** following your discharge?

Name: Relationship:

Do you have caring responsibilities for others at home? Yes ☐ No ☐

If '**yes**', please provide details:

If you are the sole caregiver for a dependant, you will need to consider making arrangements for their care during your hospital stay and after your discharge or as advised by your specialist.

Home supports

Do you currently receive any supports at home (i.e. home help, meals on wheels)? Yes ☐ No ☐

If '**yes**', please state what, and for how many hours per week:

If you think that you will require respite care for a period of time after discharge, please discuss this with your specialist. You may be responsible for any costs associated with this arrangement. **These arrangements should be organised by you prior to your admission.**

Discharge/transport

Please advise the person collecting you that the discharge time is **10am**.

Name: Contact phone number (mobile/landline):

Please feel free to add any further comments/concerns regarding discharge:

It is important to know **who** has **completed this form**. Please print and sign your name.

Name (print): Date: / /

Signature:

I am the: ☐ Patient ☐ Legal guardian ☐ Parent ☐ Other (specify):

Please return this form **at least one week** prior to your operation/procedure date

You can email this form or see page 15 of patient information booklet for more details.

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