Health Questionnaire

Royston HOSPITAL

Important!

Please deliver, post, or email this form 7–10 working days before your admission together with the completed Admission, Finance and Consent Form to:

Royston Hospital
500 Southland Road
Hastings 4122

Email: admissions@royston.co.nz

A stamped, addressed envelope is provided for posting.
If this is not possible, please make sure you bring the forms with you when you arrive for admission. If you emailed the forms to us, please bring the originals with you.

Personal Details (patient to complete)

Admisson Date:

Personal details:

Mr/Ms/Mrs/Miss/Dr

First name *Middle name* *Surname*

Preferred Name *Known as* Date of birth Age NHI No: *If known*

Gender Ethnicity Are you: NZ Citizen Permanent resident

Email

Telephone *Home* *Work* *Mobile*

If you have ever had any of the following medical conditions, please tick 'Yes' or 'No' and provide further details if applicable.

Cardiac	YES	NO	COMMENTS
High blood pressure?	☐	☐	.....
Have you ever had any problems with your heart or blood vessels?	☐	☐	.....
Chest pain or discomfort? Angina?	☐	☐	.....
Have you ever had a heart attack?	☐	☐	.....
Palpitations or irregular heartbeat?	☐	☐	.....
Any procedures, operations or investigations on your heart: surgery, stents, heart valve replacement, or an Implanted cardiac defibrillator (ICD) or Pacemaker?	☐	☐	.....
Do you have any problems with your circulation or ever had any operations on your veins or arteries?	☐	☐	.....

Respiratory	YES	NO	COMMENTS
Asthma or chronic airways disease (COPD)?	☐	☐	.....
Any other lung or breathing problems?	☐	☐	.....
Chest infections?	☐	☐	.....
Have you had a chest infection in the last four weeks and did it require steroids/medication to treat? *Please provide details if yes.*	☐	☐	.....
Loud snoring (that can be heard from other rooms)?	☐	☐	.....
Sleep aponea (or have you been told you stop breathing while asleep?)	☐	☐	.....
Do you use a CPAP machine?	☐	☐	.....

Endocrine (glands), hormonal disorders and diabetes	YES	NO	COMMENTS
Diabetes?	☐	☐	Type 1 ☐ Type 2 ☐
Do you currently use: Insulin ☐ Tablets ☐ Diet control ☐			*Please bring blood sugar recordings with you if available.*
Any other endocrine, hormone or gland problems?	☐	☐	.....
Thyroid problems?	☐	☐	.....
Adrenal or pituitary problems?	☐	☐	.....

Kidney and urinary systems	YES	NO	COMMENTS
Kidney (renal) condition? (e.g. only one kidney, dialysis)	☐	☐	.....
Kidney stones?	☐	☐	.....
Urinary problems? (e.g. Recurrent infection, bed wetting.)	☐	☐	.....
Any other kidney or urinary problems?	☐	☐	.....

Neurological	YES	NO	COMMENTS
Do you have any problems or under treatment for any neurological condition?	☐	☐	.....
Stroke, Cerebrovascular accident (CVA), or Transient Ischaemic Attack or (TIA)	☐	☐	.....
Seizures, blackouts or fainting relating to epilepsy? If yes, how often do you have seizures? When was the last time?	☐	☐	.....
Dementia or cognitive problems? (Alzheimer's, forgetfulness)	☐	☐	.....
Paraplegia or spinal problems?	☐	☐	.....
Muscle or Neurological disease e.g. MS, Parkinson's, Muscular dystrophy	☐	☐	.....
CJD or any neurological disease currently under investigation?	☐	☐	.....

Liver	YES	NO	COMMENTS
Hepatitis A, B, C, jaundice or liver condition?	☐	☐	.....
Cirrhosis?	☐	☐	.....
Gallstones?	☐	☐	.....
Any other problems?	☐	☐	.....

Blood disorders	YES	NO	COMMENTS
Blood clots in lungs or legs? (PE, DVT, thrombosis?)	☐	☐	.....
Bleeding disorder and/or family history (von Willebrands disease/hemophilia)	☐	☐	.....
Anaemia?	☐	☐	.....
Previous blood transfusion? If yes, when was the last, and what was the reason?	☐	☐	.....

Gastrointestinal	YES	NO	COMMENTS
Gastric reflux or hiatus hernia?	☐	☐	.....
If yes, is your heartburn well controlled? Please provide details.	☐	☐	.....
Any other gastrointestinal issues or procedures?	☐	☐	.....
Inflammatory bowel disease e.g. Crohns or Ulcerative Colitis?	☐	☐	.....
Diverticular disease?	☐	☐	.....
Any surgery on your bowels or stomach?	☐	☐	.....
Cancer?	☐	☐	.....

Bones and joints	YES	NO	COMMENTS
Arthritis/Rheumatoid arthritis?	☐	☐	.....
Joint replacement or orthopaedic metalware?	☐	☐	.....
Other issues?	☐	☐	.....

Skin	YES	NO	COMMENTS
Do you have any eczema/skin conditions?	☐	☐	.....
Do you currently have any cuts, scratches, sores or abrasions on your skin?	☐	☐	.....

Infection	YES	NO	COMMENTS
Are you a healthcare professional or have you stayed in hospital during the last 6 months?	☐	☐	.....
Travelled overseas in the last 6 months? If so, where and were you hospitalised?	☐	☐	.....
Transmittable diseases e.g. Hepatitis B or C, Tuberculosis, or HIV?	☐	☐	.....
Have you ever had a drug resistant infection? (MRSA, VRE, ESBL, VRSA)	☐	☐	.....
Have you had a blood transfusion in Europe 1980-1996 or a human tissue transplant prior to 1992?	☐	☐	.....
Have you received human pituitary gonadotrophin or growth hormone prior to 1990?	☐	☐	.....
Have you had COVID-19? (Coronavirus). If yes, are you under any treatment or monitoring for this condition?	☐	☐	.....
Have you had or been in contact with someone with COVID-19? (Coronavirus). If so when?	☐	☐	.....

Mental health and wellbeing	YES	NO	COMMENTS
Do you suffer from anxiety, depression, PTSD or emotional disturbance or phobias e.g. needles?	☐	☐	.....

Chronic pain	YES	NO	COMMENTS
Do you have any chronic pain issues? If yes, what is the location of the pain? How is this being managed?	☐	☐	.....

Other	YES	NO	COMMENTS
Have you ever been investigated or treated for cancer?	☐	☐	.....
Is there any other relevant medical condition you need to tell us about?	☐	☐	.....

Allergies, adverse reactions and food intolerances	YES	NO	Please describe the reaction
Do you have a latex allergy?	☐	☐	.....
Other allergies	☐	☐	.....
Adverse reactions e.g. medications or medical products	☐	☐	.....
Food intolerances	☐	☐	.....

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. Alternatively, if your pharmacist provides you with a pre-filled multi-pack, ask for a printout of the medications you are currently taking. Please also include over-the-counter and any complementary, herbal, homeopathic or other alternative therapies.

Name	Dose	When do you take your medication?	Why do you take the medication?
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

Health professionals

List the name(s) of the hospital/clinic/doctors/surgeons/nurses you see.

Name	Reason for seeing	Date of last visit
.....	.....	.....
.....	.....	.....
.....	.....	.....

Previous surgery/anaesthesia	YES	NO
Have you ever had surgery or been admitted to hospital before?	☐	☐

Operation/illness	Year	Hospital
.....	.....	.....
.....	.....	.....
.....	.....	.....

Anaesthesia related issues	YES	NO	Please describe the reaction
Do you have or have you ever had any of the following? If 'yes' or if you are uncertain, please comment in the box.			
Have you ever had any problems with a previous surgery or recovery?	☐	☐	.....
Do you have any jaw or neck problems?	☐	☐	.....
If yes, do you have any difficulty opening your mouth wide?	☐	☐	.....
Do you have any restrictions in your head or neck movement?	☐	☐	.....
Do you have any jaw problems e.g. jaw locking?	☐	☐	.....

continued over

Anaesthesia related issues *cont.*	YES	NO	Please describe the reaction
Have you been told you are difficult to intubate?	☐	☐	.....
Are there any conditions that run in your family? (e.g. malignant hyperthermia, thalassaemia, muscular dystrophy?)	☐	☐	.....
Have you had any problems while under an anaesthetic? (e.g. slow to wake, nausea and vomiting, post surgery confusion, agitation)	☐	☐	.....
Has any blood relative had problems while under an anaesthetic?	☐	☐	.....

Dietary needs

The nurse will ask you for more information on any dietary requirements you may have.

	YES	NO
Do you have any dietary requirements?	☐	☐

Please check any dietary requirements you have:

Gluten free ☐ Dairy free ☐ Lactose free ☐ Pescatarian ☐ Vegetarian ☐ Vegan ☐ Keto ☐ FOD map ☐

Other ☐

Fitness and lifestyle

How would you describe your general health? Good ☐ Fair ☐ Poor ☐

Do any symptoms limit your ability to exercise?
E.g. breathlessness, chest pain, pain in joints, leg pain. YES ☐ NO ☐ .....

Have you ever smoked? YES ☐ Ex smoker ☐ Never ☐

Do you currently smoke tobacco, eCigarettes or vape?
If yes, please provide details e.g. how many per day? YES ☐ NO ☐ .....

Do you smoke recreational drugs?
If so, what and how often? YES ☐ NO ☐ .....

Do you drink alcohol regularly?
If yes, how many units per week? YES ☐ NO ☐ .....

Are you or do you think you may be pregnant?
If yes, how many weeks? YES ☐ NO ☐ .....

Communication and culture	YES	NO	Comments
Do you have a visual or hearing impairment?	☐	☐	Hearing aids or glasses? .....
Do you have any cultural needs we should be aware of?	☐	☐	.....
Do you speak English fluently?	☐	☐	If no, which language? .....

If an external interpreter service is required, this will incur an additional cost.

Blood transfusions: Do you have any reasons which might stop you from accepting a blood transfusion?	☐	☐	.....
Human tissue: Would you like surgically removed body parts to be returned? (Excludes metalware)	☐	☐	.....

Discharge planning	YES	NO	Comments

To help the nurses plan your discharge home after your operation, we need to ask you a few general questions.

Do you require any physical support or aids? If so, what?	☐	☐	.....
Do you live alone? If yes, and your surgery is booked as a day case, have you arranged for an adult to take you home and stay with you overnight? If yes, please give detail.	☐	☐	.....
Do you have any dependents?	☐	☐	.....
Do you have any pets?	☐	☐	.....
Do you have any problems with daily activities? Can you manage around the house? With or without mobility aids? (e.g. showering, bathing, dressing)	☐	☐	.....
Do you have stairs at home?	☐	☐	.....
Have you had a fall in the last 6 months?	☐	☐	.....
Will someone be taking you home?	☐	☐	.....
Do you have someone to stay overnight with you when you get home?	☐	☐	.....
Are you currently using any community support services? If so, please list.	☐	☐	.....
Do you have any other concerns about your discharge?	☐	☐	.....
Do you have a disability we should be aware of?	☐	☐	.....

What is the best contact number to reach you on following the first few days after your discharge? .....