Southern Cross Healthcare

Patient Health Questionnaire

IMPORTANT: Please send this completed form to the Hospital where you will have your procedure/surgery.

Surname (family name): _____ **First name(s):** _____

Date of birth: _____ /_____ /_____
d m y

All questions in this questionnaire are about the person being treated at the Hospital.
If you are filling this out for your child, only provide information relating to your child's health.

List procedures/operations/hospital admissions the patient has had (start with the most recent and work backwards).

Procedures/Operations/Admissions	Year	Hospital

Has the patient ever had or does the patient currently have any of the following?

Example: **Yes** **No** **DOES THE PATIENT**
☑ ☐ Have any (joint implants) / pacemaker / heart valve / other prosthesis / implants / piercings
left hip

Please tick a Yes or No. Circle a word where appropriate. Add comments in the spaces provided.

Yes **No**

☐ ☐ Has the patient had an anaesthetic before?
☐ ☐ Has the patient or any other family member had any problems with an anaesthetic? If answered yes, please explain: _____
☐ ☐ Do you have problems opening your mouth (eg. previous jaw problems, TM joint problems)?
☐ ☐ Diabetes – diet controlled / requiring tablets
☐ ☐ Diabetes – requiring Insulin
For how long? _____
☐ ☐ High blood pressure / Palpitations / Swollen ankles
☐ ☐ Angina / Heart attack / Heart failure
☐ ☐ Stroke / TIA (transient ischaemic attack)
☐ ☐ Epilepsy / Severe headaches
☐ ☐ Blackouts / Fainting
☐ ☐ Asthma / Wheeziness
☐ ☐ Hospitalised with asthma
☐ ☐ Emphysema / Bronchitis / Croup
☐ ☐ Obstructive sleep apnoea (intermittently stopping breathing during sleep)
☐ ☐ Tuberculosis / Rheumatic fever / Heart murmur
☐ ☐ Heartburn / Acid reflux / Hiatus hernia / Indigestion / Stomach or peptic ulcer
☐ ☐ Blood clots in legs or lung
☐ ☐ Bleeding problems / Anaemia / Bruising
☐ ☐ Family history of bleeding problems
☐ ☐ Arthritis. If **YES** which joints?
_____

Yes **No**

☐ ☐ Hepatitis A / B / C / Jaundice
☐ ☐ Are you a hepatitis carrier?
☐ ☐ HIV / AIDS / risk of exposure to HIV
☐ ☐ MRSA / ESBL / VRE
☐ ☐ In the last 6 months have you been a patient or employee in a hospital/s Name of hospital/s _____
or been a patient or employee in a hospital/s overseas
Name of hospital/s _____
Name of country _____
☐ ☐ Have you had, or been in contact with anyone who has had, vomiting and/or diarrhoea in the past three days (and/or immediately preceding your admission)?
☐ ☐ Boils, skin or other infections / Septicaemia.
When? _____
☐ ☐ Substance dependency / high use (e.g. drugs, alcohol)

DOES THE PATIENT

☐ ☐ Smoke / Used to smoke? How many per day? _____
☐ ☐ Drink alcohol daily? If **YES** how much? _____
☐ ☐ Wear dentures / partial plate / have capped teeth / loose teeth
☐ ☐ Wear contact lenses / glasses / hearing aid
☐ ☐ Have any joint implants / pacemaker / heart valve / other prosthesis / implants / piercings
_____
☐ ☐ Believe you are pregnant? If **YES** state months _____
☐ ☐ Suffer from motion sickness: mild / moderate / severe
☐ ☐ Have difficulty climbing more that one flight of stairs? If **YES**, what restricts this activity? _____

Any other illnesses or conditions?

☐ ☐ If **YES** please specify: e.g. Kidney problems, Thyroid disease, Muscular Dystrophy, Liver problems, Parkinson's disease, Alzheimers, Dementia, other _____
_____
_____

If you have answered YES to any of the above questions, please ensure you provide additional information.

Does the patient take medications or remedies for:

Yes	No		Yes	No	
☐	☐	Blood thinning (e.g. warfarin, aspirin)	☐	☐	Sleeplessness
☐	☐	Heart disease or high blood pressure	☐	☐	Emotional disorders or psychiatric illness
☐	☐	Diabetes or epilepsy	☐	☐	Oral contraceptives
☐	☐	Cortisone (steroids) or anti-inflammatories			

List ALL current medicines, drugs, tablets, inhalers, injections, herbal remedies, homeopathic, complementary medicines, vitamins and other supplements:

Medications/Remedies prescribed by your doctor	Strength	Dose (How many)	Frequency (How often)	For hospital use only

Other Medications/Remedies prescribed by your doctor	Strength	Dose (How many)	Frequency (How often)	For hospital use only

PLEASE BRING ALL THE ABOVE MEDICATIONS/REMEDIES/SUPPLEMENTS IN THEIR ORIGINAL CONTAINERS TO THE HOSPITAL WITH YOU AND IDEALLY A PRINTOUT FROM YOUR PHARMACY THAT INCLUDES DOSAGE REGIME.

Yes No

☐ ☐ Has the patient ever had any **allergic reactions** to latex, iodine, medications, plasters, food or any other substance? If **YES** please list your **allergies** and describe the **reactions**:

_____

_____

_____

☐ ☐ Has the patient had a "head cold", throat/chest infection or bronchitis in the **past 4 weeks**?

IN PREPARATION FOR ADMISSION

Your weight: _____ Kgs Your Height: _____

Does the patient have any special needs? If YES, please provide more details.

Yes No

☐ ☐ Disability _____

☐ ☐ Physical support or aids _____

☐ ☐ Religious or spiritual needs _____

☐ ☐ Cultural or family/whanau needs _____

☐ ☐ Body Parts: If your procedure requires the removal of any body parts (and if this is possible), would you like them returned?

☐ ☐ Dietary requirements: Standard ☐ Diabetic ☐ Vegetarian ☐ Other ☐ _____

☐ ☐ Is there anything we need to know that you prefer not to state here?
Please discuss with your Nurse/Medical Specialist when you arrive at the Hospital.

☐ ☐ Do you have anxieties, concerns, questions or additional matters you wish to discuss before your surgery with:
Surgeon ☐ Anaesthetist ☐ Nurse ☐ Administration ☐

☐ ☐ Has the patient had blood taken for self (autologous) transfusion?

Patient / Guardian signature: _____ Date: ____ / ____ / ____
d m y

FOR Hospital USE ONLY

	PRE-ADMISSION:	ON ADMISSION:
Responses checked by (name and designation)		
Date:	____ / ____ / ____ (d / m / y)	____ / ____ / ____ (d / m / y)
Comments:		