



Patient Health Questionnaire

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

The hospital needs to **receive** all three forms at least one week prior to your admission. You can hand deliver, fax, scan and email, or post the forms. If you post the forms, please allow 1-2 extra weeks for delivery.

Please complete this questionnaire carefully as the information you supply helps us to provide you with the best and safest possible care during your stay at our hospital. The questionnaire has four sections:

- A Your general health
- B In preparation for your hospital admission
- C In preparation for your procedure
- D Your current medicines

Surname (family name) _____		Hospital Administration only (Patient label)	
First name (s) _____			
Height _____ metres	Weight _____ kilograms	Surgeon _____	
		NHI (if known) _____	
		Occupation (optional) _____	

All questions in this questionnaire are about the person being treated at the hospital (the patient). If you are filling this out for the patient, only provide information relating to the patient's health.

Section A Your General Health

A1. MEDICAL PROCEDURE HEALTH ALERTS			
Do any of the following apply to you?			
Q.	Yes	No	If Yes
1	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty climbing more than a flight of stairs <i>What restricts this activity?</i>
2	<input type="checkbox"/>	<input type="checkbox"/>	Motion sickness <i>mild moderate severe (circle one)</i>
3	<input type="checkbox"/>	<input type="checkbox"/>	Jaw problems (difficulty opening mouth) <i>Specify:</i>
4	<input type="checkbox"/>	<input type="checkbox"/>	Problems with a previous anaesthetic <i>Specify:</i>
5	<input type="checkbox"/>	<input type="checkbox"/>	Family history of problems with an anaesthetic <i>Specify:</i>
6	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker or heart valve replacement <i>Specify:</i>
7	<input type="checkbox"/>	<input type="checkbox"/>	Joint implants <i>Specify:</i>
8	<input type="checkbox"/>	<input type="checkbox"/>	Other implants or prostheses <i>Specify:</i>
9	<input type="checkbox"/>	<input type="checkbox"/>	Substance use or dependency <i>Specify:</i>
10	<input type="checkbox"/>	<input type="checkbox"/>	Former smoker <i>When did you quit?</i>
11	<input type="checkbox"/>	<input type="checkbox"/>	Currently on smoking cessation treatment <i>Specify:</i>
12	<input type="checkbox"/>	<input type="checkbox"/>	Current smoker <i>How many per day?</i>
13	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant or possibly pregnant <i>Approximate due date:</i>
14	<input type="checkbox"/>	<input type="checkbox"/>	MedicAlert bracelet or necklace wearer <i>Specify:</i>

Section A Your General Health *(continued)*

A2. YOUR MEDICAL CONDITIONS			
Do you currently have, or have you previously had, any of the following conditions?			
<i>If Yes, please circle any applicable options and provide comments in the box below.</i>			
Q.	Yes	No	
15	<input type="checkbox"/>	<input type="checkbox"/>	Breathing conditions: asthma wheeziness shortness of breath bronchitis croup emphysema COPD
16	<input type="checkbox"/>	<input type="checkbox"/>	Sleeping conditions: sleeplessness severe snoring obstructive sleep apnoea CPAP used
17	<input type="checkbox"/>	<input type="checkbox"/>	Heart conditions: palpitations irregular heart beat heart murmur angina heart attack chest pain congestive heart failure rheumatic fever
18	<input type="checkbox"/>	<input type="checkbox"/>	Stroke or Transient Ischaemic Attack (TIA)
19	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure or blood pressure controlled with medication
20	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots: deep vein thrombosis (DVT) pulmonary embolus (PE)
21	<input type="checkbox"/>	<input type="checkbox"/>	Family history of blood clots
22	<input type="checkbox"/>	<input type="checkbox"/>	Blood or bleeding conditions: anaemia bruising
23	<input type="checkbox"/>	<input type="checkbox"/>	Family history of blood or bleeding conditions
24	<input type="checkbox"/>	<input type="checkbox"/>	Stomach and digestive conditions: indigestion heartburn acid reflux hiatus hernia peptic ulcer
25	<input type="checkbox"/>	<input type="checkbox"/>	Bowel conditions: irritable bowel syndrome constipation bowel disease
26	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease: jaundice hepatitis
27	<input type="checkbox"/>	<input type="checkbox"/>	Kidney conditions
28	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes: requiring insulin requiring tablets diet controlled
29	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid conditions
30	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's disease
31	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy, seizures, blackouts or fainting
32	<input type="checkbox"/>	<input type="checkbox"/>	Migraines or severe headaches
33	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimers or dementia
34	<input type="checkbox"/>	<input type="checkbox"/>	Mental function conditions: head injury concussion confusion or disorientation
35	<input type="checkbox"/>	<input type="checkbox"/>	Mental health conditions
36	<input type="checkbox"/>	<input type="checkbox"/>	Emotional conditions: anxiety phobia post traumatic stress disorder (PTSD)
37	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
38	<input type="checkbox"/>	<input type="checkbox"/>	Neck or back conditions
39	<input type="checkbox"/>	<input type="checkbox"/>	Gum or dental health conditions
40	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis (TB)
41	<input type="checkbox"/>	<input type="checkbox"/>	HIV or AIDS
42	<input type="checkbox"/>	<input type="checkbox"/>	Infection or treatment for resistant organisms: MRSA ESBL VRE OTHER
43	<input type="checkbox"/>	<input type="checkbox"/>	Cancer – <i>If Yes, please specify and provide details of any recent treatment in the comments box below</i>
44	<input type="checkbox"/>	<input type="checkbox"/>	Other condition(s) not listed above – <i>If Yes, please specify in the comments box below</i>
RE QUESTION	YOUR COMMENT		
19	<i>GP says my blood pressure is slightly high, but am not taking any medicine. --- Example ---</i>		

Need more space for your comments? Please continue on a separate sheet and attach it to this page.

Surname (family name)

First name (s)

Hospital Administration only
(Patient label)

Section B In Preparation For Your Hospital Admission

B1. YOUR ALLERGIES, SENSITIVITIES, OR INTOLERANCES

Q. Yes No

45 Are you allergic to latex?

46 Do you have any **other allergies, sensitivities or intolerances?**

If Yes, please specify and describe the reaction using the box below

	Item	Reaction
Skin-related	Plasters --- Example ---	Rash --- Example ---
Medicine-related		
Food-related		
Other		

B2. YOUR NEEDS AND PREFERENCES

Please answer these questions to help us to tailor how we care for you.

If you answer Yes to any of these questions, we may contact you to discuss your specific needs.

Q. Yes No

If Yes

47 Do you **have a disability?**

Specify:

48 Do you have **difficulty understanding English?**

Your preferred language:

49 Do you have any **religious or spiritual needs** you would like us to know about?

Specify:

50 Do you have any **cultural or family needs** you would like us to know about?

Specify:

51 Do you have any **other special needs** you would like us to know about?

Specify:

52 If your procedure requires the **removal of body parts**, would you like them returned to you if this is possible?

53 Do you have any **dietary requirements?**

vegetarian *vegan* *diabetic*
 gluten free *halal* *dairy free*
 other _____

54 Do you have any **specific food dislikes?**

Specify:

For allergies or intolerances, refer to question 46

Section C In Preparation For Your Procedure

B1. MEDICAL PROCEDURE HISTORY																		
Q.	Yes	No																
55	<input type="checkbox"/>	<input type="checkbox"/>	Have you previously had any procedures / operations or other hospital admissions? <i>- If Yes, please outline your previous admissions in the table below. If you need more space, please continue on a separate sheet and attach it to this page</i>															
			<table border="1"> <thead> <tr> <th>Procedure or event</th> <th>Year</th> <th>Hospital</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>	Procedure or event	Year	Hospital												
Procedure or event	Year	Hospital																
C2. ANAESTHESIA CONSIDERATIONS																		
Q.	Yes	No	If Yes															
56	<input type="checkbox"/>	<input type="checkbox"/>	Have you had an anaesthetic before? <input type="checkbox"/> <i>general</i> <input type="checkbox"/> <i>spinal</i> <input type="checkbox"/> <i>epidural</i> <input type="checkbox"/> <i>unsure</i>															
57	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any of these dental features ? <input type="checkbox"/> <i>upper denture</i> <input type="checkbox"/> <i>lower denture</i> <input type="checkbox"/> <i>crown(s) / cap(s)</i> <input type="checkbox"/> <i>partial plate</i> <input type="checkbox"/> <i>loose or chipped teeth</i>															
58	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcohol ? <i>How much?</i> _____															
C3. PERSONAL ITEMS																		
Do you use any of these personal items?																		
Q.	Yes	No	If Yes, use this space to provide details, if needed															
59	<input type="checkbox"/>	<input type="checkbox"/>	Mobility aids, such as a walking stick or cane															
60	<input type="checkbox"/>	<input type="checkbox"/>	Glasses or contact lenses															
61	<input type="checkbox"/>	<input type="checkbox"/>	Hearing aids															
62	<input type="checkbox"/>	<input type="checkbox"/>	Earrings or other piercing jewellery															
C4. BLOOD CLOT AND INFECTION CONSIDERATIONS																		
Q.	Yes	No																
63	<input type="checkbox"/>	<input type="checkbox"/>	Have you completed the pre-admission risk assessment in the Blood Clots and YOU brochure?															
64	<input type="checkbox"/>	<input type="checkbox"/>	Have you recently been on a long distance flight ?															
65	<input type="checkbox"/>	<input type="checkbox"/>	In the past 3 days, have you had, or been in contact with anyone who has had, vomiting or diarrhoea ?															
66	<input type="checkbox"/>	<input type="checkbox"/>	In the past 7 days, have you experienced flu-like symptoms , or been in contact with anyone diagnosed with influenza ?															
67	<input type="checkbox"/>	<input type="checkbox"/>	In the past 4 weeks, have you had a head cold, throat or chest infection, or bronchitis ?															
68	<input type="checkbox"/>	<input type="checkbox"/>	In the past 12 months, have you travelled overseas , or been a patient or employee in a hospital or rest home in New Zealand or overseas? <i>- If Yes, please specify</i> _____															
69	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any boils, cuts, sores, scratches or other skin or urine infections ?															
C5. OTHER CONCERNS																		
Q.	Yes	No																
70	<input type="checkbox"/>	<input type="checkbox"/>	Is there anything we need to know that you prefer not to write on this questionnaire? <i>- If Yes, please discuss with your nurse or medical specialist when you arrive at the hospital</i>															
71	<input type="checkbox"/>	<input type="checkbox"/>	Do you have anxieties, concerns, or questions you wish to discuss before your procedure? <i>- If Yes, who would you like to speak with?</i> <input type="checkbox"/> <i>your surgeon</i> <input type="checkbox"/> <i>your anaesthetist</i> <input type="checkbox"/> <i>a nurse</i> <input type="checkbox"/> <i>one of our admin staff</i>															

