Manuka Street Hospital

Patient Health Questionnaire

AFFIX PATIENT LABEL
(Office Use Only)

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.
*Please complete all sections and both sides of the form, and post or fax **10 days prior** to surgery or as soon as possible to: Manuka Street Hospital, 36 Manuka Street, Nelson 7010. Fax to: (03) 548 2767 or email to: administration@manukastreet.org.nz*

Personal Details in preparation for your admission

Surname: First Name(s):

Date of birth: Age: Telephone:

Your weight: kg. Your height: cm. Your BMI (if known):

Admission Date: Surgeon:

Operation:

Previous Anaesthetics

Have you had any anaesthetics before? Yes ☐ No ☐
If yes, please list all operations in the space below:

Procedures / Operations	Year	Hospital

Have you or any of your family ever had a serious reaction or difficulties or problems with anaesthetics? (e.g. post-op nausea / vomiting, drug reactions etc.) Yes ☐ No ☐

If yes, please specify:

Medication / Remedies / Supplements

Do you regularly take any medicines, drugs, tablets, inhalers, injections, herbal remedies, homeopathic, complementary medicines, vitamins or other supplements? Yes ☐ No ☐

If yes, please list below: *(use another page if necessary)*

Medications / Remedies	Dose	Frequency

Please bring all the above, in their original containers with contents clearly identified to the hospital with you and a printout from your General Practitioner or Pharmacy (a hand written list is not acceptable).

Allergies and Sensitivities

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Do you have any allergies and / or sensitivities to the following?

If yes, name the item and describe the reaction in the space below:

Medications	Yes ☐	No ☐	
Foods	Yes ☐	No ☐	
Plasters / tape / skin preparations (e.g. iodine, chlorhexidine)	Yes ☐	No ☐	
Latex	Yes ☐	No ☐	
Other	Yes ☐	No ☐	
Do you wear a Medic Alert bracelet?	Yes ☐	No ☐	If yes, why?

Smoking Status and Alcohol Consumption

Do you currently smoke?	Yes ☐	No ☐	If yes, how many per day?
Have you recently quit smoking?	Yes ☐	No ☐	If yes, how long ago?
Do you smoke marijuana?	Yes ☐	No ☐	If yes, how often?
Do you drink alcohol?	Yes ☐	No ☐	If yes, average intake per week?

Have you ever had or do you currently have any of the following?

(Please tick Yes or No. Circle a word where appropriate; add comments in the space provided below).

Respiratory / Cardiac Conditions

Problems with neck or opening your mouth e.g. jaw problems, rheumatoid arthritis, ankylosing spondylitis	Yes ☐	No ☐
Spinal problems e.g. spinal surgery, ruptured disc	Yes ☐	No ☐
Obstructive Sleep Apnoea (OSA) / Severe snoring (intermittently stopping breathing during sleep)	Yes ☐	No ☐
Lung conditions e.g. Asthma, Chronic Obstructive Pulmonary Disease (COPD) / emphysema, shortness of breath	Yes ☐	No ☐
Chest pain, angina, heart attack, heart failure Irregular heartbeat or palpitations	Yes ☐	No ☐
Cardiac Bypass, Aortic surgery, Valve surgery, Cardiac stent or Pacemaker	Yes ☐	No ☐
High blood pressure requiring medication.	Yes ☐	No ☐

If yes, please provide your three most recent readings:

1. ____/____ Date: 2. ____/____ Date: 3. ____/____ Date:

High Cholesterol requiring medication	Yes ☐	No ☐

Exercise Tolerance

I can perform all physical activity without getting short of breath	Yes ☐	No ☐
I get short of breath when performing more strenuous activities e.g. walking up a hill or flight of stairs	Yes ☐	No ☐
I get short of breath when performing day to day activities e.g. walking on the flat	Yes ☐	No ☐
I get short of breath walking 20 – 100 metres	Yes ☐	No ☐
I get short of breath at rest and am mostly housebound. I cannot carry out any physical activity without getting short of breath	Yes ☐	No ☐

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Have you ever had or do you currently have any of the following?
(Please tick Yes or No. Circle a word where appropriate; add comments in the space provided below).

Other Conditions

Diabetes controlled by Diet / Tablets / Insulin	Yes ☐	No ☐
Thyroid / pituitary problems	Yes ☐	No ☐
Blood disorders or clotting problems or family history of blood disorders e.g. Anaemia	Yes ☐	No ☐
Blood clots (legs or lungs)	Yes ☐	No ☐
Abnormal bruising or bleeding	Yes ☐	No ☐
Stroke, Cerebrovascular Accident (CVA), Transient Ischaemic Attack (TIA)	Yes ☐	No ☐
History of Epilepsy or seizures	Yes ☐	No ☐
Migraines or severe headaches.	Yes ☐	No ☐
If yes, how often?		
Liver conditions – Hepatitis A, B or C, jaundice	Yes ☐	No ☐
HIV / AIDS / risk of exposure to HIV	Yes ☐	No ☐
Kidney conditions	Yes ☐	No ☐
Heartburn / Acid Reflux / Hiatus Hernia / Stomach or Peptic Ulcers / Indigestion	Yes ☐	No ☐
Substance dependency e.g. Morphine or Oxycodone	Yes ☐	No ☐
Depression / Anxiety / Psychiatric Illness	Yes ☐	No ☐
Dementia / Alzheimer's / Confusion day or night time	Yes ☐	No ☐

General Health

Do you have dentures, plates or crowns etc.?	Yes ☐	No ☐
Could you be pregnant? (female patients only)	Yes ☐	No ☐
Infection or treatment for the following multi drug resistant organisms: Methicillin-resistant Staphylococcus aureus (MRSA) / Extended-spectrum beta-lactamase (ESBL) / Vancomycin-resistant enterococci (VRE)	Yes ☐	No ☐
In the last 6 months have you ever been a patient or employee in a hospital(s)?	Yes ☐	No ☐
If yes, name of hospital(s)		
In the last 6 months have you ever been a patient or employee in a hospital(s) overseas?	Yes ☐	No ☐
If yes, name of hospital(s) and country		
Do you have a disability?	Yes ☐	No ☐
Do you require physical support or aides?	Yes ☐	No ☐
Do you have any special dietary requirements? If yes, please indicate:	Yes ☐	No ☐

Vegetarian ☐ Gluten Free ☐ Dairy Free ☐ Diabetic ☐ Other ☐

Continued over

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Support Services

Do you require the services of an interpreter?	Yes ☐	No ☐
If yes, which language(s):		
Do you require the services of an advocate?	Yes ☐	No ☐
Do you have any special religious or spiritual needs / cultural or family / whānau needs?	Yes ☐	No ☐
If your procedure requires the removal of body parts, would you like them returned (if possible)?	Yes ☐	No ☐
If yes, please detail:		
Is there anything else we need to know that you prefer not to state here?	Yes ☐	No ☐
If yes, please discuss with your Nurse / Medical Specialist when you arrive at the Hospital.		

Name: Date:

Signature:

If not the patient, state relationship to patient:

Comments: *(use another page if necessary)*

For Hospital use only

Ward Manager: Pre-admission:	Yes ☐	No ☐	Initials:	Date:	Time:
Theatre Manager:	Checked ☐		Initials:	Date:	Time:
Referred to Dr:					
Administration:	Entered on WebPAS ☐		Initials:	Date:	Time:
Diet request form completed:	Yes ☐	No ☐	Initials:	Date:	Time: