Manuka Street Hospital

Patient Health Questionnaire

IMPORTANT: *Please complete all sections of the form at least 3 weeks prior to your admission. You can: hand deliver, post (Manuka Street Hospital 36 Manuka Street, Nelson 7010) or complete these on-line by saving a copy to your computer first then email back) Alternatively, you can print out the PDF version to complete manually and email it back to administration@manukastreet.org.nz*

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

We have endeavored to provide enough space in each area. However, If there is not enough room to list or explain, please add in your email, or if posting - add to a separate sheet.

Surname *(family name)*

_____

First name *(s)*

_____

Height _____**metres**

Weight _____**kilograms**

To support your ongoing care your discharge information will be sent to your GP.

If you DO NOT want this, please tick ☐

Hospital Administration only

(Patient label)

Surgeon _____

NHI ***(if known)*** _____

Occupation _____

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

MEDICAL PROCEDURE HEALTH ALERTS

Do any of the following apply to you?

Q.	Yes	No		*If yes*
1.	☐	☐	Difficulty climbing more than a flight of stairs	*What restricts this activity*
2.	☐	☐	Jaw problems (difficulty opening mouth)	*Specify:*
3	☐	☐	Problems with previous anaesthetic	*Specify:*
4.	☐	☐	Family history of problems with anaesthetic	*Specify:*
5.	☐	☐	Pacemaker or heart valve replacement	*Specify:*
6.	☐	☐	Breastfeeding	*Specify:*
7.	☐	☐	Implants or prostheses	*Specify:*
8.	☐	☐	Substance use or dependency	*Specify:*
9.	☐	☐	Former Smoker (including e-cigarettes and vapes)	*When did you give up?*
10.	☐	☐	Currently on smoking cessation therapy	*Specify:*
11.	☐	☐	Current Smoker (including e-cigarettes and vapes)	*How many per day?*
12.	☐	☐	Pregnant or possibly pregnant	*Approximate due date*
13.	☐	☐	MedicAlert bracelet or necklace wearer	*Specify:*
14.	☐	☐	Blood Clots: Deep vein thrombosis (DVT), Pulmonary embolus (PE)	*Specify:*
15.	☐	☐	Family history of blood clots	*Specify:*
16.	☐	☐	Family History of blood or bleeding conditions	*Specify:*
17.	☐	☐	Blood or bleeding conditions	(select one)

Hospital Administration only

(Patient label)

Section A Your General Heath

A2. YOUR MEDICAL CONDITIONS

Do you currently have, or have you previously had, any of the following conditions?

If Yes, please select any of the specific conditions that affect you.

Q.	Yes	No		
18.	☐	☐	**Breathing conditions:**	asthma ☐ wheeziness ☐ shortness of breath ☐ bronchitis ☐ croup ☐ emphysema ☐ COPD ☐
19.	☐	☐	**Sleeping conditions:**	Sleeplessness ☐ severe snoring ☐ obstructive sleep apnoea ☐ CPAP used ☐
20.	☐	☐	**Heart conditions:**	palpitations ☐ irregular heartbeat ☐ heart murmur ☐ Angina ☐ heart attack ☐ chest pain ☐ congestive heart failure ☐ rheumatic fever ☐
21.	☐	☐	**Stroke or Transient Ischaemic Attack (TIA)**	
22.	☐	☐	**High blood pressure or blood pressure controlled with medication**	
23.	☐	☐	**Motion sickness**:	Mild ☐ Moderate ☐ Severe ☐
24.	☐	☐	**Stomach and digestive conditions**:	indigestion ☐ heartburn ☐ acid reflux ☐ hiatus hernia ☐ peptic ulcer ☐
25.	☐	☐	**Bowel conditions:**	irritable bowel syndrome ☐ constipation ☐ bowel disease ☐
26.	☐	☐	**Liver disease:**	jaundice ☐ hepatitis ☐
27.	☐	☐	**Kidney conditions**	
28.	☐	☐	**Diabetes:**	requiring insulin ☐ requiring tablets ☐ diet controlled ☐
29.	☐	☐	**Thyroid conditions**	
30.	☐	☐	**Parkinson's disease**	
31.	☐	☐	**Neurology:**	Epilepsy ☐ seizures ☐ blackouts ☐ fainting ☐
32.	☐	☐	**Migraines or severe headaches**	
33.	☐	☐	**Alzheimer's or dementia**	
34.	☐	☐	**Mental function conditions**:	head injury ☐ concussion ☐ confusion ☐ disorientation ☐
35.	☐	☐	**Mental health conditions**:	depression ☐ asperger's ☐ ADHD ☐ other ☐
36.	☐	☐	**Emotional conditions:**	anxiety ☐ phobia ☐ (PTSD) ☐
37.	☐	☐	**Arthritis**	
38.	☐	☐	**Neck or back condition**	
39.	☐	☐	**Gum or dental health conditions**	
40.	☐	☐	**Tuberculosis (TB)**	
41.	☐	☐	**HIV or AIDS**	
42.	☐	☐	**Infection or treatment for resistant organisms**:	MRSA ☐ ESBL ☐ VRE ☐ OTHE ☐
43.	☐	☐	**Cancer** – If yes, please specify and provide details of any recent treatment in the comments box below	
44.	☐	☐	**Other condition(s) not listed above** – If yes, please specify in the comments box below	

RE QUESTION	YOUR COMMENT
19	*GP says my blood pressure is slightly high, but am not taking any medicine - - - Example - - -*

Surname

_____

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		

MEDICAL PROCEDURE HEALTH ALERTS

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?**	
48.	☐	☐	Do you have **difficulty understanding English?**	*Specify:*
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* ☐ *halal* ☐ *dairy f ree* ☐ *gluten free* ☐ *other (specify):*
54.	☐	☐	Do you have any **specific food dislikes?** For allergies or intolerances, refer to question 46	

Hospital Administration only

(Patient label)

Section C In Preparation For Your Procedure

B1 . MEDICAL PROCEDURE HISTORY

Q.	Yes	No		
55.	☐	☐	Have you previously had any procedures / operations or other hospital admissions? – 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	

Procedure or event	Year	Hospital

C2. ANAESTHESIA CONSIDERATIONS

Q.	Yes	No		
56	☐	☐	Have you had an anaesthetic before?	☐ *general* ☐ *spinal* ☐ *epidural* ☐ *unsure*
57.	☐	☐	Do you have any of these dental features?	☐ *upper denture* ☐ *lower denture* ☐ *crown(s)/cap(s)* ☐ *partial plate* ☐ *loose or chipped teeth*
58.	☐	☐	Do you drink alcohol?	*How much?*

C3. PERSONAL ITEMS

Do you use any of these personal items?

Q.	Yes	No		
59.	☐	☐	Mobility aids, such as a walking stick or cane	*Specify:*
60.	☐	☐	Hearing aids, Glasses or contact lenses	*Specify:*

C4. BLOOD CLOT AND INFECTION CONSIDERATIONS

Q.	Yes	No	
61.	☐	☐	Have you recently been on a **long-distance flight?** *If yes, When?*
62.	☐	☐	In the past 3 days, have you had, or been in contact with anyone who has had, **vomiting or diarrhoea?**
63	☐	☐	In the past 7 days, have you experienced **flu-like symptoms**, or been in contact with anyone diagnosed with **influenza?**
64.	☐	☐	In the past 4 weeks, have you had **a head cold, throat or chest infection, or bronchitis?**
65.	☐	☐	In the past 12 months, have you **travelled overseas**, *– If yes, please specify the country*
66.	☐	☐	In the past 12 months have you been a patient or employee in a hospital or rest home in New Zealand or overseas? *– If yes, please specify the country*
67.	☐	☐	Do you have any **boils, cuts, sores, scratches** or other **skin or urine infections**? *– If yes, please specify*
68.	☐	☐	Have you had Covid-19 *– If yes, when state the latest occurrence:*

C5. OTHER CONCERNS

Q.	Yes	No		
69.	☐	☐	Is there anything we need to know that you prefer not to write on this questionnaire? *– If yes, please discuss with your nurse or medical specialist when you arrive at the hospital*	
70..	☐	☐	Do you have anxieties, concerns, or questions you wish to discuss before your procedure? – If yes, who would you like to speak with?	☐ your surgeon ☐ your anaesthetist ☐ a nurse ☐ admin staff

Surname *familyname*

Firstname

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Section D Your Current Medicines

For your safety, it is extremely important that your doctors and nurses know precisely which medicines you are currently using.

Important instructions.

1. List below <u>all</u> medicines you currently use, and bring them with you to the hospital in their <u>original containers</u>
2. To ensure you are clear what to include, please use the MEDICINE REMINDERS table (right→)
3. If you have a medication card or printout from your GP or pharmacist, please bring it with you to the hospital, as well as completing the list below.

MEDICINE REMINDERS
Which of the examples below apply to you?

There are many types of medicine		Medicines come in many forms		Medicines are taken for many common conditions	
prescription medicines	*vitamins*	*tablets*	*patches*	*heart disease*	*infections*
herbal medicines	*supplements*	*capsules*	*suppositories*	*high blood pressure*	*diabetes*
natural medicines	*contraceptives*	*inhalers*	*creams*	*blood thinning*	*sleeplessness*
homeopathic remedies	*steroids*	*drops*	*injections*	*dietary deficiencies*	*epilepsy*
over-the-counter medicines		*syrups*	*other liquids*	*emotional conditions*	

D1. YOUR CURRENT MEDICINES

Patient to complete – list <u>all</u> medicines you currently use.

Name of medicine	Strength	How much you use, and when	HOSPITAL USE ONLY **Reconciled:** Yes (**Y**) | No (**N**) | Not available (**NA**) *Medicine container*	*Medication card*	*Patient or whānau/ family*	*Other (state) eg, 'phoned GP'*	*Comment if No*	*ON ADMISSION: Date/time last taken*
Paracetamol --- Example ---	*500mg*	*2 capsules every 6 hours*	–	–	–	–	–	–

If required, please continue on the reverse

This is not a prescription or an instruction to administer medicines

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Section D Your Current Medicines *(continued)*

Continued from reverse.

D1. YOUR CURRENT MEDICINES			HOSPITAL USE ONLY					
Patient to complete – list all medicines you currently use.			**Reconciled:** Yes (**Y**) | No (**N**) | Not available (**NA**)					
Name of medicine	**Strength**	**How much you use, and when**	*Medicine container*	*Medication card*	*Patient or whānau/ family*	*Other (state) eg, 'phoned GP'*	*Comment if No*	*ON ADMISSION: Date/time last taken*

This is not a prescription or an instruction to administer medicines

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