AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

SURNAME: _____ NHI: _____

FIRST NAMES: _____

DATE OF BIRTH: ____/____/____ SEX: _____

Please attach patient label here

Pre-Assessment Health Questionnaire

To be completed by patients

This information is important and confidential. Please complete both sides of this form fully.
If you need help to complete this form or need an interpreter, please ask a staff member.

Are the above name and details correct? _____

What would you like us to call you (i.e. Mr or Mrs or by your first name)? _____

Do you require an Interpreter? Yes ☐ No ☐ Language _____

Do you have any particular cultural/religious needs? _____

_____

Do you have any difficulties with speech, hearing or vision?

_____

What operation will you be having? _____

For Day Surgical patients only:

Will you have someone to take you home by car? Yes ☐ No ☐

Will you have a responsible adult to look after you overnight? Yes ☐ No ☐

Health Questionnaire **Do you suffer from, or have you ever suffered from, the following:**

	Yes	No		Yes	No		Yes	No
High blood pressure	☐	☐	Persistent cough	☐	☐	Stroke / TIA	☐	☐
Previous heart attack	☐	☐	Shortness of breath	☐	☐	Blackouts / Fainting	☐	☐
Heart murmur	☐	☐	Obstructive Sleep Apnoea	☐	☐	Medication for long term pain	☐	☐
Palpitations or unusual beating	☐	☐	Cancer	☐	☐	Recreational Drugs	☐	☐
Artificial heart valve or pacemaker	☐	☐	Anaemia	☐	☐	Steroids (e.g. Prednisone)	☐	☐
Chest pains / Tightness or angina	☐	☐	Bleeding or excessive bruising	☐	☐	Joint or metal implant	☐	☐
How often _____			Blood clots in lungs/legs	☐	☐	Arthritis	☐	☐
When did it last occur _____			Blood transfusion	☐	☐	Do you smoke	☐	☐
Hiatus hernia/Heartburn/Indigestion	☐	☐	Hepatitis / Jaundice	☐	☐	How many daily _____		
Previous rheumatic fever	☐	☐	Are HIV+ or have AIDS	☐	☐	If you stopped, when _____		
Asthma	☐	☐	Kidney problems	☐	☐	Do you drink alcohol Yes ☐ No ☐		
Tuberculosis	☐	☐	Diabetes	☐	☐	If yes, how much _____		
Emphysema or bronchitis	☐	☐	Epilepsy	☐	☐	How often _____		

I had surgery on my brain or spinal cord prior to 1992 Yes ☐ No ☐

I received pituitary - derived hormones for infertility or short stature prior to 1985 Yes ☐ No ☐

I was involved in a CJD surgical instrument contact incident. Yes ☐ No ☐

Women Only. Are you or could you be pregnant? Yes ☐ No ☐ If yes, how many weeks _____

If you answered "yes" to any of the above, please give further details below:

Please list all previous admissions to hospital/Consultation with private specialist

Reason for admission	Hospital	Date
		/ /
		/ /
		/ /
		/ /

PRE ASSESSMENT HEALTH QUESTIONNAIRE

CR2049

PRE ASSESSMENT HEALTH QUESTIONNAIRE

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

SURNAME: _____ NHI: _____

FIRST NAMES: _____

DATE OF BIRTH: ____/____/____ SEX: _____

Please attach patient label here

Pre-Assessment Health Questionnaire

Please list all current medications (including natural remedies / complementary therapies)

Drug name	Dose	Times of Day Taken

Do you have any allergies to medication, tablets, plasters, food, LATEX or any other substance Yes ☐ No ☐

If "Yes", please list

Substance	Type of reaction

Do you have a problem opening your mouth? (e.g. previous jaw problems) Yes ☐ No ☐

Have you been told of any difficulties during previous anaesthetics? Yes ☐ No ☐

Do you have dentures, partial plate, capped or loose teeth? Yes ☐ No ☐

Does lying flat make you breathless? Yes ☐ No ☐

How many pillows do you sleep with at night? _____

What physical activities do you take part in on a regular basis? Please tick those that apply.

Walking ☐ Gym work ☐ Tennis ☐ Golf ☐ Other (specify) _____

How many flights of stairs can you climb without getting out of breath?

One flight ☐ Two flights ☐ Three flights or more ☐

My activity is restricted by: Shortness of breath ☐ Chest pain ☐ Joint pain ☐ Muscle pain ☐ Not applicable ☐

Are there any major illnesses, to your knowledge, among your blood relatives?

e.g. diabetes, muscular dystrophy, malignant hyperthermia Yes ☐ No ☐ If "Yes", please list

Have you or any of your family had problems with an anaesthetic? Yes ☐ No ☐ If "Yes", please outline

Do you suffer from any other conditions (including mental health) **not already noted or do you wear a medic alert bracelet?** Yes ☐ No ☐ If "Yes", please outline

Do you have any concerns or questions about your anaesthetic or surgery?

The details above have been completed by patient / guardian / relative / other **(please circle)**

Signed: _____ Date: ____/____/____

Staff to complete

Height: cm	**Weight:** Kg	**BMI:** kg/m^2
BP:	**HR:**	**O_2 Sats (air)**
To see GP for blood pressure control: ☐		**Peak flow** ℓ/min

CR2049