NELSON DAY SURGERY

Pre-Procedure Health Questionnaire

Date:_____ PROCEDURE:_____

Please complete the questions by ticking the appropriate answer and giving additional information if necessary, in the spaces provided.
Please make sure that you have included all relevant information to the best of your knowledge.
It is not necessary for your family doctor to complete this form.

	No	Yes	
Do you need an interpreter? (State language)			
Do you wish to have access to the Māori health service?			

Your height in CM:	**Your weight in KG:**	**BMI:**

Next of kin details:

Name:_____ **Relationship:**_____

Contact phone number:_____

A. Anaesthetics	No	Yes	Your Comments:
Have you ever had an anaesthetic?			
Were there any problems? (e.g. nausea, vomiting, airway problems, difficulty breathing)			
Has a family member had an unusual reaction to an anaesthetic? If yes, what happened?			
Do you have any concerns about the anaesthetic or hospital stay you would like to discuss with us? If yes, what are they?			

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B. Do you have or have you ever had?	No	Yes	Your Comments:
High Blood Pressure			
Chest pain			
Heart attack			
Unusual thumping in chest or palpitations			
Heart pacemaker			
Artificial heart valves			
Rheumatic heart disease			
Stroke/TIA			
Frequent indigestion or heartburn or reflux			
Epilepsy or fits			
Blackouts or fainting If yes, state reason			
Asthma or lung problems If YES, do you use an inhaler more than twice a day?			
Severe snoring, stopping breathing during sleep or shortness of breath (apnoea)			
Kidney problems			
Swollen Ankles			
Jaw, neck or back problems (circle)			
Muscle or nerve disease (e.g. Multiple Sclerosis)			
Blood clots in the legs or lungs			
Blood disorders (state)			
Tuberculosis			
Diabetes (what type?)			
Hepatitis or jaundice If YES, was this anaesthetic related?			
Thyroid or Pituitary problems (state)			
Treatment for cancer			
Are there any medical conditions that run in the family? (state)			
Joint Replacement, Metal Plates or Pins			
Are there any conditions not mentioned above? (state)			

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C. General Questions	No	Yes	Your Comments
Do you cough and bring up any blood?			
Do you bruise easily?			
Do you smoke or vape?			
How many cigarettes per day?			
Did you ever smoke?			
If so, what year did you stop?			
Do you drink alcohol regularly?			
If yes, what, and how many drinks per day?			
Do you think you may be pregnant?			

D. How far can you walk without stopping?	No	Yes	Your Comments
More than 2 flights of stairs			
2 flights of stairs			
1 flight of stairs			
Half a flight of stairs			
Around the house, on the flat			

E. Allergies or Sensitivities – List all allergies including drugs, lotions, sticking plaster, latex. Also please let us know if you are GLUTEN FREE or have any other dietary requirements i.e. vegetarian.	Please describe your reaction. For example wheeze, rash, vomiting etc.

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F. List all the medications you take. This includes medications such as... Blood thinners, aspirin, inhalers, eye drops, ointments, alternative medicines such as Arnica and St John's Wort and vitamins etc.		
Medication	**Amount**	**How Often**

G. Discharge Arrangements/Information/Aftercare Consent

Following the procedure you are not able to drive a vehicle, operate any machinery or go on any public transport. You must not drink alcohol or sign any legal documents for 24 hours due to the medications given. You need to follow any advice given and instructions. You should consider your employment requirements for the following day.

YOU MUST HAVE SOMEONE TO PICK YOU UP AFTER YOUR PROCEDURE. YOU WILL NEED HAVE SOMEONE TO STAY WITH YOU OVERNIGHT. PLEASE PROVIDE THESE DETAILS:

NAME:_____ _____ CONTACT PHONE NUMBER:_____

RELATIONSHIP:_____

Patient Confirmation of Understanding:

Patient Signature: **Date:**_____

Additional Patient Information:	
Is there any other information you would like to provide us with so that we can ensure your experience with us is as comfortable as possible? **This information is confidential.**	