TASMAN DAY SURGERY

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Pre-Clinic Gynaecology Health Questionnaire Only

Name: **Date of Birth:** **Phone Number:**

PROCEDURE REQUESTED:

Please complete the questionnaire carefully by ticking the appropriate answer and giving additional information, if necessary, in the spaces provided. This information is strictly confidential
Please make sure that you have included all relevant information to the best of your knowledge to help us to provide you with the best and safest possible care during your visit.

	No	Yes	Comment
Which ethnicity do you identify with and do you need an interpreter? (Please state language)			
Do you wish to have access to the Māori health service?			
Do you have any cultural or spiritual needs you would like us to know about?			

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

Please confirm the name of your Doctor and Medical Practice:

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. Obstetric and Gynecological History	No/NA	Yes	Details:
Have you self-referred, or do you have a good understanding of why your GP has referred you through to Tasman Day Surgery Gynaecology? As best you are able, please explain in your own words.			
Are you premenopausal? If yes, please provide details about your menstrual periods, including: when your periods started, frequency, duration, regularity, heaviness, any bleeding between periods, any medications used to regulate your periods currently and in the past.			
Are you postmenopausal? If yes, please describe when your periods stopped, how old you were when your periods started, how your periods were prior to stopping, and any history of vaginal bleeding since.			
Are you sexually active? If yes, do you experience any post-coital bleeding or intra-coital pain?			
Are you actively trying to get pregnant, or do you wish to preserve the possibility of fertility for the future? If yes, please explain.			
Are you using contraception? If no, have you used contraception in the past? Please provide details.			
Have you ever been pregnant. If yes, please provide details of each pregnancy including when and the result (e.g. miscarriage, vaginal birth, instrumental birth, Caesarean Section, abortion).			
Are your cervical screens up to date? Please provide details, including any history of abnormalities and treatment.			
Have you ever had a sexually transmitted infection (STI). If yes, please describe when, and whether/how you were treated.			
Have you ever had any surgeries on your uterus, or fallopian tubes. If yes, please explain when and what.			
Have you had any other operations on your pelvis or abdomen? If yes, please explain when and what.			
Do you have any issues passing bowel motions or urine? If yes, please describe.			

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Is there any family history of cancer, particularly your parents, siblings or children, and especially of bowel, breast, ovarian or uterine cancer? If yes, please describe it in detail.			
In the last 2 years, have you had any imaging (e.g. ultrasound, MRI, or CT scan) performed on your pelvis? If yes, when and where?			
Is there anything else regarding your obstetric of gynaecological history that you want us to know.			

C. 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			
Gum or dental health conditions			
Epilepsy or fits			
Blackouts, fainting or motion sickness If yes, state reason			
Do you have a history of falls?			
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)			
Arthritis			
Muscle or nerve disease (e.g., Multiple Sclerosis)			
Blood clots in the legs or lungs			
Blood disorders (state)			
Tuberculosis			
Diabetes (what type?)			

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Hepatitis, jaundice, or liver disease 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			
Mental function conditions: head injury/concussion/confusion or disorientation			
Mental health conditions			
Emotional conditions: anxiety/phobia/post-traumatic stress (PTSD)			
Are there any conditions not mentioned above? (state)			

D. 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 take any form of recreational drugs?			
If yes, what type and how often?			
Do you think you may be pregnant?			

E. 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			

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F. 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.

G. **ARE YOU ON MEDICATION? Y or N (PLEASE CIRCLE)** Please list all the medications you take including recreational drugs. 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

Additional Patient Information:	
Please let us know if there were any further information you would like to provide us with so that we can ensure your experience with us is as safe and as comfortable as possible?	

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H. 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 days. If you have a surgical procedure, you may need up to two weeks to recover.

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: ________________________________

NEXT OF KIN (If different from above)____

Patient Confirmation of Understanding:

Patient Signature: ______________________________ Date: _________________________

Could you please let us know how you found out about us i.e., doctors, media etc!