TASMAN DAY SURGERY

Pre-Procedure Health Questionnaire

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:

If this is a self-referral, please include the reason for your request for this procedure below:

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.	No	Yes	When and in which hospital and if possible, the outcome of these procedures
Abdominal or Pelvic Surgery			
Colonoscopy			
CT Colonography			
Gastroscopy			
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?)			
Hepatitis, jaundice, or liver disease If YES, was this anaesthetic related?			
Thyroid or Pituitary problems (state)			
Treatment for cancer			

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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			

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.

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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?	

H. Doctor's Consent

Do you consent to the Doctor involved in your care accessing your information on the national patient record system? This helps ensure they have all the necessary information to support the best possible health outcomes for you.

Please circle:

Yes

No

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I. 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!