



Patient Health History

This form is part of your health assessment prior to surgery. It is dealt with in strict confidence. Please answer all questions.

Name: _____ Date: _____
 Weight: _____ kg Height: _____ cm

Please answer the question by ticking the box Yes No

1. Do you have any allergies or sensitivities to any medications, food or other substances (eg sticking plaster, latex) Yes No
If yes, please list medication, food or substance and reaction you have. _____
2. Do you have any special dietary requirements Yes No
If yes, please specify _____
3. Do you smoke, or have you ever smoked Yes No
If yes, how many a day and for how many years _____
4. Do you drink alcohol Yes No
If yes, how much and how often _____
5. Do you take street drugs or narcotics other than those prescribed for you Yes No
6. Do you have any vision or hearing difficulties Yes No
If yes, please describe _____
7. Do you have any religious beliefs/practices or cultural needs we need to be aware of Yes No
If yes, please describe _____
8. Do you have any skin problems eg. ulcers, bruises, wounds or dressings Yes No
If yes, please describe _____
9. Mobility (If you are currently using walking aides, please bring these with you when you are admitted)
 Independent Using Equipment Requiring Assistance Completely Dependant
 Please specify _____
10. Have you had any previous operations or admissions to hospital Yes No
If so, when, where and what for _____

Reason / Operation	Year	Hospital

11. Do you take any regular medications (including the contraceptive pill, inhalers, herbal remedies, eye-drops, sprays or regular over the counter medications eg. aspirin) Yes No

Medication	Dose	Frequency

12. Does anyone assist you with the administration of your own medication Yes No



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Do you suffer from or have you ever had any of the following:.....

- | | Yes | No |
|---|--------------------------|--------------------------|
| 13. High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, is this being monitored/treated by your GP | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Heart problems (angina, irregular pulse, fluid on lungs, pacemaker) Please list: | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Rheumatic fever | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. A heart murmur | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been hospitalised due to your asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Lung Problems (bronchitis, emphysema, TB) | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. A stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Epilepsy If yes, when was your last seizure | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Hepatitis, Yellow Jaundice or HIV | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, what treatment are you on <input type="checkbox"/> Diet <input type="checkbox"/> Tablets <input type="checkbox"/> Insulin | | |
| 23. Blood clots to the legs or lungs | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Blood disorders, If yes, please explain | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Rheumatoid arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Hiatus hernia, heartburn or acid reflux | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Obstructive sleep apnoea (told you snore loudly then stop breathing) | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, do you use a CPAP machine | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Are you, or could you be pregnant | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Have you or a blood relative ever had any problems with any anaesthetic | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, who and what happened | | |
| 30. Any other Medical Conditions (eg. Alzheimer's, psychiatric history) | | |

Discharge Planning

- | | | |
|--|--------------------------|--------------------------|
| 31. Do you live alone | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, who is going to care for you on discharge | | |
| 32. Do you have caring responsibilities for others at home eg. partner, children, pets | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Have you had any recent falls | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please explain | | |
| 34. Do you receive Home Health Services (eg. Meals on Wheels, District Nurse) | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please list | | |
| 35. Has your surgeon arranged admission to a rehabilitation unit for you if required | <input type="checkbox"/> | <input type="checkbox"/> |

Please note: The hospital discharge time is 10.00am



CHECKLIST

- Please ensure you have:
- Completed the Request & Consent for Treatment Form with surgeon
 - Completed Patient Registration Form
 - Completed Patient Health History Form

Send all paperwork one week prior to admission.
 For Mercy Hospital admissions to PO Box 9911, Newmarket
 For Ascot Hospital admissions to Private Bag, Remuera

