Please ensure this form is received by Boulcott Hospital at least one week prior to your admission.

Boulcott Hospital

AFFIX PATIENT LABEL HERE

Health Questionnaire/ Nursing Assessment

Post to: Boulcott Hospital Admissions
PO Box 31459
Lower Hutt 5040

Drop off to: Boulcott Hospital Reception
666 High Street
Lower Hutt 5040

Email to: bookings@boulcotthospital.co.nz **(Please bring original copy with you on admission)**

SURGEON: **OPERATION DATE:** / /

PERSONAL DETAILS

Patient Name:
Mr/Mrs/Ms/Miss/Mstr/Dr

Surname *Given names*

NHI Number (if known) **Date of Birth** / /

Height *Metres* **Weight** *Kilograms* **BMI** *If known*

Please complete – this information is important for your anaesthetist

PREVIOUS HOSPITAL ADMISSIONS

Have you ever had surgery or been admitted to hospital before? ☐ **YES** ☐ **NO**

Year:	Operation/Illness:	Hospital:
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

HEALTH PROFESSIONALS

List the name(s) of the clinic / doctors / nurses / specialists you see.

Name:	Reason for seeing:	Date of last visit:
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

HEALTH QUESTIONNAIRE

HEALTH QUESTIONNAIRE

If you have ever had any of the following medical conditions, please tick 'Yes' or 'No' and provide further details if applicable.

HEART AND LUNG HEALTH	YES	NO	COMMENTS
High blood pressure	☐	☐	.....
Chest pain / Angina	☐	☐	.....
Heart attack	☐	☐	.....
Palpitations or irregular heartbeat	☐	☐	.....
Pacemaker or implanted cardiac defibrillator (ICD)	☐	☐	.....
Heart surgery e.g. stents, valve replacement, bypass	☐	☐	.....
Heart failure	☐	☐	.....
Rheumatic fever	☐	☐	.....
Heart murmur	☐	☐	.....
Any other heart conditions?	☐	☐	.....
Asthma	☐	☐	.....
In hospital for asthma	☐	☐	.....
COPD, Emphysema, Chronic Bronchitis	☐	☐	.....
Lung surgery	☐	☐	.....
Is your lung condition well controlled?	☐	☐	.....

SLEEP HEALTH	YES	NO	COMMENTS
Obstructive Sleep Apnoea	☐	☐	.....
Do you use a CPAP machine?	☐	☐	.....
Has anyone observed you stop breathing in your sleep?	☐	☐	.....
Do you snore loudly? (loud enough to be heard through closed doors)	☐	☐	.....
Do you often feel tired, fatigued or sleepy during the daytime?	☐	☐	.....

DIABETES	YES	NO	COMMENTS
Diabetes	☐	☐	.....
Type 1 ☐ Type 2 ☐ Diet controlled ☐			.....

Do you currently use:

Insulin ☐ Tablets ☐ Other injections ☐ Insulin pump ☐ Continuous Glucose Monitor (CGM) ☐

Patient ID

NEUROLOGICAL HEALTH

	YES	NO	COMMENTS
Are you under treatment for a neurological condition e.g. head injury,concussion?	☐	☐	.....
Stroke (CVA) or minor stroke (TIA)	☐	☐	.....
Epilepsy / fits / seizures / blackouts If yes, when was the last time?	☐	☐	.....
Migraines or bad headaches	☐	☐	.....
Paraplegia or areas of impaired sensation	☐	☐	.....
Muscle or neurological condition e.g. MS, Parkinson's, Muscular Dystrophy	☐	☐	.....
Dementia/ Alzheimer's / memory loss / episodes of confusion	☐	☐	.....
Severe agitation or confusion while in hospital following surgery	☐	☐	.....
Depression, anxiety, PTSD, phobias	☐	☐	.....
Neurodivergence	☐	☐	.....

BLOOD DISORDERS

	YES	NO	COMMENTS
Blood clots in the legs (DVT) or lungs (PE)	☐	☐	.....
Bleeding disorder or family history of Von Willebrands, haemophilia, factor V Leiden	☐	☐	.....
Anaemia	☐	☐	.....

OTHER CONDITIONS

	YES	NO	COMMENTS
Thyroid condition	☐	☐	.....
Liver condition	☐	☐	.....
Kidney (renal) condition e.g. one kidney, dialysis, kidney stones	☐	☐	.....
Urinary problems e.g. bed wetting, Incontinence, recurrent infections	☐	☐	.....
Urinary catheter or self-catheterise	☐	☐	.....
Gastric reflux / hiatus hernia / stomach ulcer	☐	☐	.....
Inflammatory bowel disease / Crohn's / Ulcerative colitis	☐	☐	.....
Bowel or stomach surgery	☐	☐	.....
Any other gastrointestinal issues	☐	☐	.....
Arthritis / rheumatoid / psoriatic arthritis	☐	☐	.....
Joint replacements	☐	☐	.....
Eczema / skin conditions	☐	☐	.....
Chronic pain syndrome	☐	☐	.....
Any other medical condition you feel we should know about	☐	☐	.....

Patient ID

GENERAL ANAESTHETICS	YES	NO	COMMENTS
Have you ever had a general anaesthetic	☐	☐	.....
Any problems / side effects / complications with recovery e.g. slow to wake, nausea & vomiting, confusion, agitation	☐	☐	.....
Has any blood relative had problems / reactions to anaesthetic?	☐	☐	.....
Any conditions that run in your family e.g. Malignant hypothermia, muscular dystrophy, Thalassaemia	☐	☐	.....
Any jaw problems e.g. jaw locking Difficulty opening mouth wide	☐	☐	.....
Restrictions with neck movement	☐	☐	.....
Can you walk up 2 x flights of stairs without getting breathless?	☐	☐	.....
If no, can you walk for a distance of 100 metres on a flat surface without getting breathless?	☐	☐	.....
If no, do you get breathless with activities such as showering or dressing?	☐	☐	.....
Do you suffer from motion sickness?	☐	☐	.....
Do you have dentures	☐	☐	plates ☐ capped ☐ loose teeth ☐

INFECTION CONSIDERATIONS	YES	NO	COMMENTS
Have you travelled overseas in the last 12 months?	☐	☐	Location(s): .....
Have you had any contact with a hospital overseas in the last 12 months?	☐	☐	Location(s): .....
Have you been admitted to a NZ hospital out of the Greater Wellington region in the last 12 months?	☐	☐	Location(s): .....
Transmittable diseases e.g. TB, HIV / Hepatitis B, C	☐	☐	.....
Multi drug resistant organism or treatment for MRSA, VRE, ESBL, VRSA, CPE/CPO or Candida Auris	☐	☐	.....
Do you currently have any cuts, scratches, sores or acne on your skin?	☐	☐	.....

ALLERGIES, SENSITIVITIES	YES	NO	COMMENTS
Medications	☐	☐	.....
Foods	☐	☐	.....
Plasters / tapes	☐	☐	.....
Latex	☐	☐	.....
Other	☐	☐	.....

LIFESTYLE / CULTURAL	YES	NO	COMMENTS
Do you have any dietary requirements	☐	☐	.....
Have you ever smoked	☐	☐	Ex smoker ☐ .....
Do you currently smoke tobacco / vape	☐	☐	Amount per day .....
Do you use recreational drugs?	☐	☐	.....
If so, what & how much & how often			.....
Do you drink alcohol regularly?	☐	☐	.....
If yes, how much per week			.....
Do you think you may be pregnant?	☐	☐	.....
Do you have any cultural / religious needs we should be aware of	☐	☐	.....

Patient ID

LIFESTYLE / CULTURAL

	YES	NO	COMMENTS
Do you speak English fluently	☐	☐	**if no,** which language .....
Do you require an interpreter (fee may apply)	☐	☐	.....
Would you like any surgically removed body parts or metalware returned to you if possible?	☐	☐	.....
Do you have any piercings that can't be removed	☐	☐	.....
Any vision impairment?	☐	☐	Contacts ☐ Glasses ☐
Hearing impairment	☐	☐	.....
Do you use a hearing aid?	☐	☐	Left ☐ Right ☐ Bilateral ☐
Do you have a cochlear implant?	☐	☐	.....
Any other special needs you would like us to know about	☐	☐	.....

MEDICATIONS

	YES	NO	COMMENTS
Do you take any regular medications?	☐	☐	.....

(If YES, please complete the separate medication reconciliation form)

DISCHARGE PLANNING

	YES	NO	COMMENTS
Do you have any restrictions with mobility?	☐	☐	.....
Do you use any mobility aids e.g. crutches, wheelchair?	☐	☐	.....
Do you have any stairs at home?	☐	☐	.....
Have you had a fall in the last 12 months?	☐	☐	.....
Can you get out of a chair without using your hands?	☐	☐	.....
Have you stopped doing some activities because you're afraid you might lose your balance?	☐	☐	.....
Do you worry about falling?	☐	☐	.....

Do you currently receive assistance or have you arranged any community services for after your discharge? ☐ **YES** ☐ **NO**

COMMENTS

Are you going to your own home on discharge?	☐	☐	If NO, please state where: .....
Do you have a responsible adult to stay with you on the night of discharge following a day procedure?	☐	☐	N/A ☐ .....
Do you have someone to drive you home?	☐	☐	.....
Do you anticipate any problems on discharge? If YES, please explain:	☐	☐	.....

.....

The above details have been completed by: (Please sign below)

Patient ☐ Guardian ☐ Relative ☐ Other ☐ Please state.....

Signature: ..... Date: .....

If within 7 days prior to your admission you have any of the following; cough, cold, flu-like symptoms, vomiting, diarrhoea, broken or infected areas of skin – please contact Boulcott Hospital Admissions – Phone 04 5697 555 ext 814.

HOSPITAL ADMINISTRATION ONLY

Reviewed by:

Date: / /

FOR HOSPITAL USE ONLY

FOR PRE-ASSESSMENT ☐ YES ☐ NO ☐ **Phone** ☐ **Nurse Clinic** ☐ **Anaesthetist**

PRE-EXISTING RISKS IDENTIFIED – DOCUMENT ADVICE GIVEN:

- ☐ Cardiac surgery/arrhythmias/ Pacemaker / MI
- ☐ OSA +/- CPAP machine
- ☐ Diabetes
- ☐ Taking anti-coagulants
- ☐ Bleeding disorder
- ☐ Weight ≥ 100kgs
- ☐ BMI ≥ 40
- ☐ Skin integrity / high pressure area risk
- ☐ Airway complications
- ☐ Anaesthetic reactions
- ☐ History of DVT/ PE
- ☐ Allergies
- ☐ Tissue / Metalware Return
- ☐ Fall Risk
- ☐ CVA / TIA
- ☐ Discharge arrangements

Anaesthetic issues:.....

.....

.....

Medical History: .....

.....

.....

Pre-op medication instructions:.....

.....

.....

Other including social or discharge issues:

.....

.....

.....

External Notes Requested ☐

Theatre Notified ☐ Yes ☐ No

Anaesthetist notified ☐ Yes .....(name + date) ☐ No

Nurse Signature: .....

Patient ID