GILLIES
A SOUTHERN CROSS HOSPITAL

FORM 3
PATIENT HEALTH QUESTIONNAIRE

Return all forms to arrive at Gillies Hospital at least ONE WEEK before admission

IMPORTANT: Please send this completed form to the hospital where you will have your procedure/surgery.

The hospital needs to receive all three forms at least one week prior to your admission. You can hand deliver, fax, scan and email, or post the forms. If you post the forms, please allow 1-2 extra weeks for delivery.

Please complete this questionnaire carefully as the information you supply helps us to provide you with the best and safest possible care during your stay at our hospital. The questionnaire has four sections:

A Your general health
B In preparation for your hospital admission
C In preparation for your procedure
D Your current medicines - please return even if blank

Surname *(family name)* _____

First name *(s)* _____

Hospital Administration only
(Patient label)

Height _____ metres

Weight _____ kilograms

Surgeon _____

NHI *(if known)* _____

Occupation *(optional)* _____

All questions in this questionnaire are about the person being treated at the hospital (the patient). If you are filling this out for the patient, only provide information relating to the patient's health.

Section A Your General Health

A1. MEDICAL PROCEDURE HEALTH ALERTS

Do any of the following apply to you?

Q.	Yes	No		If **Yes**
1	☐	☐	Difficulty climbing more than a flight of stairs	*What restricts this activity?*
2	☐	☐	Motion sickness	*mild / moderate / severe (circle one)*
3	☐	☐	Jaw problems *(difficulty opening mouth)*	*Specify:*
4	☐	☐	Problems with a previous anaesthetic	*Specify:*
5	☐	☐	Family history of problems with an anaesthetic	*Specify:*
6	☐	☐	Pacemaker or heart valve replacement	*Specify:*
7	☐	☐	Joint implants	*Specify:*
8	☐	☐	Other implants or prostheses	*Specify:*
9	☐	☐	Substance use or dependency	*Specify:*
10	☐	☐	Former smoker	*When did you quit?*
11	☐	☐	Currently on smoking cessation treatment	*Specify:*
12	☐	☐	Current smoker	*How many per day?*
13	☐	☐	Pregnant or possibly pregnant	*Approximate due date:*
14	☐	☐	Breastfeeding	
15	☐	☐	MedicAlert bracelet or necklace wearer	*Specify:*

Surname *(family name)*

First name *(s)*

Hospital Administration only
(Patient label)

Section A Your General Health *(continued)*

A2. YOUR MEDICAL CONDITIONS

Do you currently have, or have you previously had, any of the following conditions?
If Yes, please circle any applicable options and provide comments in the box below.

Q.	Yes	No	
16	☐	☐	**Breathing conditions:** asthma | wheeziness | shortness of breath | bronchitis | croup | emphysema | COPD
17	☐	☐	**Sleeping conditions:** sleeplessness | severe snoring | obstructive sleep apnoea | CPAP used
18	☐	☐	**Heart conditions:** palpitations | irregular heart beat | heart murmur | angina | heart attack | chest pain congestive heart failure | rheumatic fever - *If **Yes** please provide any relevant specialist letters*
19	☐	☐	**Stroke or Transient Ischaemic Attack (TIA)**
20	☐	☐	**High blood pressure or blood pressure controlled with medication**
21	☐	☐	**Blood clots:** deep vein thrombosis (DVT) | pulmonary embolus (PE)
22	☐	☐	**Family history of blood clots**
23	☐	☐	**Blood or bleeding conditions:** anaemia | bruising
24	☐	☐	**Family history of blood or bleeding conditions**
25	☐	☐	**Stomach and digestive conditions:** indigestion | heartburn | acid reflux | hiatus hernia | peptic ulcer
26	☐	☐	**Bowel conditions:** irritable bowel syndrome | constipation | bowel disease
27	☐	☐	**Liver disease:** jaundice | hepatitis
28	☐	☐	**Kidney conditions**
29	☐	☐	**Diabetes:** requiring insulin | requiring tablets | diet controlled
30	☐	☐	**Thyroid conditions**
31	☐	☐	**Parkinson's disease**
32	☐	☐	**Epilepsy, seizures, blackouts or fainting**
33	☐	☐	**Migraines or severe headaches**
34	☐	☐	**Alzheimers or dementia**
35	☐	☐	**Mental function conditions:** head injury | concussion | confusion or disorientation
36	☐	☐	**Mental health conditions**
37	☐	☐	**Emotional conditions:** anxiety | phobia | post traumatic stress disorder (PTSD)
38	☐	☐	**Arthritis**
39	☐	☐	**Neck or back conditions**
40	☐	☐	**Gum or dental health conditions**
41	☐	☐	**Tuberculosis (TB)**
42	☐	☐	**HIV or AIDS**
43	☐	☐	**Infection or treatment for resistant organisms:** MRSA | ESBL | VRE | OTHER
44	☐	☐	**Cancer** – *If **Yes**, please specify and provide details of any recent treatment in the Comments box below*
45	☐	☐	**Other condition(s) not listed above** - *If **Yes**, please specify in the Comments box below*

RE QUESTION	YOUR COMMENT
20	*GP says my blood pressure is slightly high, but am not taking any medicine.* *- - - Example - - -*

Need more space for your comments? Please continue on a separate sheet and attach it to this page.

Surname *(family name)*

First name *(s)*

Hospital Administration only
(Patient label)

Section B In Preparation For Your Hospital Admission

B1. YOUR ALLERGIES, SENSITIVITIES, OR INTOLERANCES

Q.	Yes	No	
46	☐	☐	Are you **allergic to latex?**
47	☐	☐	Do you have **any other allergies, sensitivities or intolerances?** *If **Yes**, please specify and describe the reaction using the box below*

	Item	Reaction
Skin-related	*Plasters* *- - - Example - - -*	*Rash* *- - - Example - - -*
Medicine-related		
Food-related		
Other		

B2. YOUR NEEDS AND PREFERENCES

Please answer these questions to help us to tailor how we care for you.
*If you answer **Yes** to any of these questions, we may contact you to discuss your specific needs.*

Q.	Yes	No		*If **Yes***
48	☐	☐	Do you have a **disability**?	*Specify:*
49	☐	☐	Do you have **difficulty understanding English**?	*Your preferred language:*
50	☐	☐	Do you have any **religious or spiritual needs** you would like us to know about?	*Specify:*
51	☐	☐	Do you have any **cultural or family needs** you would like us to know about?	*Specify:*
52	☐	☐	Do you have any **other special needs** you would like us to know about?	*Specify:*
53	☐	☐	If your procedure requires the **removal of body parts,** would you like them returned to you if this is possible?	
54	☐	☐	Do you have any **dietary requirements**?	☐ *vegetarian* ☐ *vegan* ☐ *diabetic* ☐ *gluten free* ☐ *halal* ☐ *dairy free* ☐ *breast fed* ☐ *bottle fed* ☐ *other* _____
55	☐	☐	Do you have any **specific food dislikes**? *For allergies or intolerances, refer to question **47***	*Specify:*

Surname *(family name)*

First name *(s)*

Hospital Administration only
(Patient label)

Section C In Preparation For Your Procedure

C1. MEDICAL PROCEDURE HISTORY

Q.	Yes	No	
56	☐	☐	**Have you previously had any procedures / operations or other hospital admissions?** *– If **Yes**, please outline your previous admissions in the table below. If you need more space, please continue on a separate sheet and attach it to this page*

Procedure or event	Year	Hospital

C2. ANAESTHESIA CONSIDERATIONS

Q.	Yes	No		
57	☐	☐	Have you had an **anaesthetic** before?	☐ *general* ☐ *spinal* ☐ *epidural* ☐ *unsure*
58	☐	☐	Do you have any of these **dental features**?	☐ *upper denture* ☐ *lower denture* ☐ *crown(s) / cap(s)* ☐ *partial plate* ☐ *loose or chipped teeth*
59	☐	☐	Do you **drink alcohol**?	*How much?* _____

C3. PERSONAL ITEMS

Do you use any of these personal items?

Q.	Yes	No		*If **Yes**, use this space to provide details, if needed*
60	☐	☐	Mobility aids, such as a walking stick or cane	
61	☐	☐	Glasses or contact lenses	
62	☐	☐	Hearing aids	
63	☐	☐	Earrings or other piercing jewellery	

C4. BLOOD CLOT AND INFECTION CONSIDERATIONS

Q.	Yes	No	
64	☐	☐	Have you completed the pre-admission risk assessment in the **Blood Clots and YOU** brochure?
65	☐	☐	Have you recently been on a **long distance flight**?
66	☐	☐	In the past 3 days, have you had, or been in contact with anyone who has had, **vomiting or diarrhoea**?
67	☐	☐	In the past 7 days, have you experienced **flu-like symptoms**, or been in contact with anyone diagnosed with **influenza**?
68	☐	☐	In the past 4 weeks, have you had a **head cold, throat or chest infection, or bronchitis**?
69	☐	☐	In the past 12 months, have you travelled **overseas**? If yes where?
70	☐	☐	In the past 12 months, have you been a patient or employee in a rest home or hospital in New Zealand or overseas? If yes where? _____
71	☐	☐	Do you have any **boils, cuts, sores, scratches or other skin or urine infections**?

C5. OTHER CONCERNS

Q.	Yes	No		
72	☐	☐	Is there anything we need to know that you prefer not to write on this questionnaire? *– If **Yes**, please discuss with your nurse or medical specialist when you arrive at the hospital*	
73	☐	☐	Do you have anxieties, concerns, or questions you wish to discuss before your procedure? *– If **Yes**, who would you like to speak with?*	☐ *your surgeon* ☐ *your anaesthetist* ☐ *a nurse* ☐ *one of our admin. staff*

Surname *(family name)* _____ **First name** *(s)* _____

Hospital Administration only
(Patient label)

Section D Your Current Medicines

For your safety, it is extremely important that your doctors and nurses know precisely which medicines you are currently using. Please return this page even if you are not on any regular medication and it is blank.

Important instructions.

1. List below all medicines you currently use, and bring them with you to the hospital in their original containers
2. To ensure you are clear what to include, please use the MEDICINE REMINDERS table (right →)
3. If you have a medication card or printout from your GP or pharmacist, please bring it with you to the hospital, as well as completing the list below.

MEDICINE REMINDERS

Which of the examples below apply to you?

There are many **types** of medicine		Medicines come in many **forms**		Medicines are taken for many **common conditions**	
prescription medicines	vitamins	*tablets*	*patches*	*heart disease*	*infections*
herbal medicines	supplements	*capsules*	*suppositories*	*high blood pressure*	*diabetes*
natural medicines	contraceptives	*inhalers*	*creams*	*blood thinning*	*sleeplessness*
homeopathic remedies	steroids	*drops*	*injections*	*dietary deficiencies*	*epilepsy*
over-the-counter medicines		*syrups*	*other liquids*	*emotional conditions*	

D1. YOUR CURRENT MEDICINES

Patient to complete – list all medicines you currently use.

Name of medicine	**Strength**	**How much you use, and when**	HOSPITAL USE ONLY **Reconciled:** Yes (**Y**) | No (**N**) | Not available (**NA**)					
			Medicine container	*Medication card*	*Patient or whanau/ family*	*Other (state) eg, 'phoned GP'*	*Comment if No*	*ON ADMISSION: Date/time last taken*
Paracetamol - - - Example - - -	*500mg*	*2 capsules every 6 hours*	–	–	–	–	–	–

If required, please continue on the reverse

This is not a prescription or an instruction to administer medicines

Surname *(family name)*

First name *(s)*

Hospital Administration only
(Patient label)

Section D Your Current Medicines *(continued)*

Continued from reverse.

D1. YOUR CURRENT MEDICINES			HOSPITAL USE ONLY					
Patient to complete – list all medicines you currently use.			**Reconciled:** Yes (**Y**) | No (**N**) | Not available (**NA**)					
Name of medicine	**Strength**	**How much you use, and when**	*Medicine container*	*Medication card*	*Patient or whānau/ family*	*Other (state) eg, 'phoned GP'*	*Comment if No*	*ON ADMISSION: Date/time last taken*

This is not a prescription or an instruction to administer medicines

GILL J003408 01/17 (SCHL040)