PATIENT HEALTH QUESTIONNAIRE

MercyAscot
GREENLANE + EPSOM + TAKAPUNA

PLEASE RETURN THIS FORM TO ASCOT HOSPITAL **AT LEAST ONE WEEK** PRIOR TO YOUR OPERATION/PROCEDURE DATE

Dear Patient

The information requested in this form will help us assess your needs and plan your care for your booked admission to MercyAscot. All information will be treated in strict confidence.

When answering the questions, please do not write 'see my notes' or words to that affect because we do not have your clinical notes. Please answer as accurately as possible.

Please answer **all questions** on each page even if you think they are irrelevant to your circumstances.

Please bring any relevant X-rays/CT/MRI scans (CD discs) with you, along with any mobility aids, CPAP machines etc., to the hospital. If you develop any coughs, colds, infections or wounds before your admission, contact the hospital on 09 520 9500.

We look forward to helping you prepare for your operation/procedure.

Regards,

Admissions Unit Nurses

IF FAXING OR SCANNING SEND BOTH SIDES OF BOTH PAGES.

YOUR DETAILS

Full Name: Date of Birth: / /

Planned Procedure:

Home Phone Number: ( ) Mobile Number: ( )

NHI No: (if known) Date of Surgery: / /

FOR HOSPITAL USE ONLY

Pre-Admission Review:

Action Taken: Date: / /

Date unable to contact (1st Attempt): / /

Date unable to contact (2nd Attempt): / /

Investigations required (please review any existing results)

FBC Renal Coag G+H LFT INR CXR MDRO swabs ECG ECHO

Other tests (specify):

Name: Designation:

Signature:

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DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? If yes, please give details below

	Yes	No
High Blood Pressure		
Heart Attack		
Heart Murmurs		
Artificial Heart Valve		
Chest Pains/Angina		
Coronary Angiogram or Stents		
Rheumatic Fever		
AF/Palpitations/Arrhythmias		
Ischaemic Heart Disease		
CORD (Chronic Obstructive Respiratory Disease)		
Asthma		
Emphysema/Bronchitis		
Persistent Cough		
Shortness of Breath		
Obstructive Sleep Apnoea		
Does lying flat make you breathless?		
Stroke/CVA/TIA		
Anaemia/Bleeding Disorders		
Blood Clots		
Epilepsy/Seizure		
Blackouts/Fainting		

	Yes	No
Heartburn/Reflux		
Diabetes		
Diet controlled		
Tablet controlled		
Insulin controlled		
Renal/Kidney Disease		
Hepatitis (A / B / C)		
HIV/AIDS		
Tuberculosis		
Have you or a blood relative ever had any problems during or after anaesthesia?		
Problems opening your mouth or with neck stiffness?		
Malignant Hyperthermia		
Taken Human Growth Hormones prior to '92		
Brain or spinal surgery which included the use of a dura mater graft?		
Are you or could you be pregnant?		
Have you suffered motion sickness or post-op nausea and vomiting?		
History of Cancer?		

	Yes	No
Pacemaker		
Joint Implants or Metalware		
Arthritis		
Mobility: Use Equipment (e.g. crutches/frame)		
Completely Dependant		
History of Falls		
Is activity restricted by: Shortness of Breath?		
Joint Pain?		
Muscle Pain?		
Current Skin Problems (e.g. ulcers, wounds, eczema, boils)		
Wear glasses/contact lenses		
Other vision impairments?		
Hearing difficulties		
Do you or have you ever smoked?		
If 'yes', how much?		
If 'yes',for how long?		
When did you give up?		
Do you drink alcohol?		
If yes, how many units **weekly** (Units/Weekly) (1 standard glass wine or ½ glass beer = 1 unit)		
Recreational Drugs		
Special Dietary Requirements		

If you answered 'yes' to any of the questions above then please give details, including treatment. **If you require more space, attach an additional sheet**.

Do you have any other medical conditions not already covered, or is there anything else we should know about you e.g. Parkinson's, mental illness, Alzheimer's, muscle/nerve disease? Yes No

If 'yes' please give details:

Do you have any religious beliefs/practices or cultural needs we should be aware of? Yes No

If 'yes' please give details:

If you have a body part removed during surgery, would you like it returned to you? Yes No

Are you waiting to see (or have recently seen) your doctor or hospital specialist about a health condition unrelated to the proposed operation/procedure you are currently being assessed for? Yes No

If 'yes' please give details:

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Full Name:

Have you lived or worked overseas in the six months prior to your admission? Yes ☐ No ☐

Have you ever had MRSA , ESBL or VRE infection? Yes ☐ No ☐

Have you been in a hospital in NZ, including MercyAscot, or overseas **within the last six months**? Yes ☐ No ☐

Do you work in a health care facility? Yes ☐ No ☐

Height ______ m Weight ______ kg

This information is important. **Do not leave this blank.** If you do not know, an estimate is acceptable.

Are you allergic/sensitive to any :

If 'yes' please name the items and describe reaction:

	Yes	No	If 'yes' please name the items and describe reaction
Medications			
Foods			
Latex			
Plasters/tape/skin preparations (e.g. iodine, chlorhexidine)			
Other			

Please list **all** previous admissions to hospital for operations/procedures and/or medical reasons. Please include where and when. **(Estimate if unsure)**. **If you require more space, attach an additional sheet**.

Reason for admission	Hospital	Month/Year

Please list **all** medicines – tablets, inhalers, patches etc. prescribed by your doctor or **over the counter** (include any herbal or natural remedies or dietary supplements). **If you require more space, attach an additional sheet**.

Name of Drug	Strength	Dose	Frequency

Does anyone assist you with administration of your own medication? Yes ☐ No ☐

If 'yes' please give details:

Is your medication packed in "compliance" (blister) packaging? Yes ☐ No ☐

PLEASE BRING ALL YOUR MEDICATIONS, IN ORIGINAL PACKETS, WITH YOU TO HOSPITAL.

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DISCHARGE PLANNING

Being prepared for your discharge is just as important as being prepared for your admission. As part of your discharge plan we will anticipate the day of discharge prior to your arrival at the hospital. This will help relieve your anxiety and prepare you for your discharge home.

You will need someone to stay with you for at least 24 hours after discharge. This may be longer depending on your surgery.

Please complete the section below so we can see what care and support you will need to ensure a safe and speedy recovery.

CARER SUPPORT:

Current living arrangements? Tick one.

☐ Live alone ☐ Live with others i.e. partner/children

☐ Have caring responsibilities for others at home. Please specify:

If you are the sole caregiver for a dependant, you will need to consider making arrangements for their care during your hospital stay and up to five days after your discharge or as advised by your surgeon.

Who will be caring for **you** following your discharge?:

Name: Relationship:

Address:

Phone Number (mobile/landline):

FORMAL SUPPORTS:

Do you currently receive any formal supports (i.e. home help, meals on wheels)? Yes ☐ No ☐

If 'yes', please state who, and for how many hours per week.

You will need to notify your formal supports of your hospital admission date and proposed discharge date.

If you think that you will require respite care for a period of time after discharge, please discuss this with your surgeon. You may be responsible for any costs associated with this arrangement. These arrangements should be organised by you prior to your admission.

DISCHARGE/TRANSPORT:

Please advise the person collecting you that the discharge time is **10am**.

Name: Contact Phone Number (mobile/landline):

Please feel free to add any further comments/concerns regarding discharge:

It is important to know **who** has **completed this form**. Please **print and sign your name**.

Print Name (in full:) Date: / /

Signature:

I am the ☐ patient ☐ legal guardian ☐ parent ☐ other (specify)

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