HEALTH QUESTIONNAIRE: Form 3

ROYSTON HOSPITAL

Completing and Submitting your Health Questionnaire

If you have been asked to attend an anaesthetic clinic appointment, please take this form and Form 1 with you. Otherwise return it to Royston Hospital at the same time as you return Forms 1, 2 and 4.

(Patient / Guardian: Please sign and complete this page and the inside page)

NAME ______________________ Date of Birth ______________

Surgeon ______________________ Phone No/s ______________

DO YOU SUFFER FROM OR HAVE YOU EVER HAD: YES NO (tick)

1 Heart attack, angina or chest pain? ☐ ☐
2 High blood pressure? ☐ ☐
3 Palpitations or unusual heart beats? ☐ ☐
4 Heart pacemaker / artificial heart valves? ☐ ☐
5 Shortness of breath on slight exertion or at night? ☐ ☐
6 Asthma, Chronic Bronchitis or Emphysema? ☐ ☐
7 Recent sore throat, flu or chest infection? ☐ ☐
8 Rheumatic Fever, Tuberculosis or Diabetes? ☐ ☐
9 Hepatitis, Jaundice, AIDS, Liver or Kidney problems? ☐ ☐
10 Tendency to bleed or bruise easily or clotting disorder? ☐ ☐
11 Stomach ulcers or heartburn? ☐ ☐
12 Blackouts, strokes, epilepsy, neurological or neuromuscular problems? ☐ ☐
13 History of blood clots in legs or lungs? ☐ ☐
14 A blood transfusion in Europe 1980-1996 or human tissue transplant prior to 1992? ☐ ☐
15 Any other serious illnesses? ☐ ☐
16 Have you ever had any **allergic** or other adverse reactions to any medication/xray dye/food/latex or plasters? ☐ ☐

17 What medications are you taking? Include those prescribed by a Doctor and any purchased at a pharmacy, supermarket (eg Paracetamol) or health food shop (eg natural remedies)

IMPORTANT

- Please obtain a printout from your GP of all medications you are taking.
- Please also bring all medications you are currently taking **in their original container** to hospital on the day of admission and when attending an Anaesthetic Clinic appointment.

Medication	Dose	How often	Repeat

18 Have you had any previous operations? *List with approximate dates:*

19 Have you or any of your family ever had any problems during or after an anaesthetic? ☐ ☐
20 Do you smoke? ☐ Yes ☐ No If "Yes" how many per day? ________ Would you like to quit? ☐ ☐
21 Do you drink alcohol daily? If "Yes" how much? ________ ☐ ☐
22 Do you have capped teeth, full/partial plates/braces? ☐ ☐
23 Do you have problems with neck or jaw movement? ☐ ☐
24 Do you have any special nursing requirements? ☐ ☐
24 Females: Are you or could you be pregnant? ☐ ☐

If you have answered 'YES' to Questions 1-16, please give brief details below:

I AM AWARE of my pre-operative fasting requirements YES ☐

I ACKNOWLEDGE that I should not drink alcohol, drive a motor vehicle, operate complex machinery or take other than prescription medicines for at least 24 hours after my procedure YES ☐

DAY STAY PATIENTS ONLY: I have arranged for a responsible adult to collect me and stay overnight after my procedure YES ☐

Patient / Guardian signature ______________________ Date ________

Guardian Name (if applicable) ______________ including relationship to patient ______________

Please open and complete inside page

Patient Name: ____________________

Surname Given names

PATIENT / GUARDIAN: PLEASE COMPLETE QUESTIONS 1 – 10

Date of Birth: ____________________

1. Language — YES NO (tick)

Is English your first language? ☐ ☐

If "No" please answer the following questions:

- Would you like us to arrange an interpreter? *(There is a cost involved)* ☐ ☐ Language: ____________________
- Will you use a family member as an interpreter? ☐ ☐

2. Confidentiality — YES NO (tick) If 'YES' give brief details

Do you have any visiting restrictions? ☐ ☐ ____________________

Do you have any other confidentiality requirements? ☐ ☐ ____________________

3. Dietary Needs

Do you have special dietary needs? ☐ ☐ ____________________

Have you lost significant weight in the last 3 months without trying? ☐ ☐ ____________________

4. Cultural Care

Do you have any cultural needs we should be aware of? ☐ ☐ ____________________

Would you like us to return any surgically removed body parts or metalware? ☐ ☐ ____________________

5. Spiritual Care

Would you like to be visited by a chaplain? ☐ ☐ ____________________

Would you like a visit from a minister / priest of your own faith? ☐ ☐ ____________________

6. Pain and Comfort

Do you currently have a wound / broken skin / rash? ☐ ☐ ____________________

Do you have any pain? Where ____________________

Severity: Mild / Moderate / Severe

Type: New / Long Term

7. Activities of Daily Living

Do you have a disability we should know about? ☐ ____________________

Do you have, or use, any of the following? (tick as appropriate)

☐ Implants	☐ Plates	☐ Pins	☐ Joint restrictions *(which joint: ________________)*
☐ Walking Aids	☐ Frames	☐ Crutches	☐ Stick ☐ Wheelchair
☐ Visual Impairment	☐ Glasses	☐ Contacts	
☐ Hearing Impairment	☐ Hearing Aids	☐ Other ____________________	

Have you had any falls in the last six months? ☐ ☐ ____________________

Do you have any stairs at home? ☐ ☐ ____________________

Do you have any problems with speech? ☐ ☐ ____________________

Do you need assistance with toileting? ☐ ☐ ____________________

Do you need assistance with showering? ☐ ☐ ____________________

Do you need assistance with dressing? ☐ ☐ ____________________

8. Discharge arrangements you have made

Are you going to your own home on discharge? ☐ ☐ ____________________

Someone to drive you home? ☐ ☐ ____________________

Someone to stay with you on the night of discharge? ☐ ☐ ____________________

Do you have any dependants at home? ☐ ☐ ____________________

Do you anticipate any problems on discharge? ☐ ☐ ____________________

9. Do you currently receive assistance or have you arranged any Community Services

ACC Home Care? ☐ ☐ ____________________

Home Help Services? ☐ ☐ ____________________

District Nurses? ☐ ☐ ____________________

Other? ☐ ☐ ____________________

10. Is there anything else you wish to add that could assist us with your care?

____

NOTE: if within seven days of your admission you have any of the following: flu, cold, broken or infected areas of skin, vomiting / diarrheoa or suffer an asthma attack - please contact your surgeon.

Please be aware you may be contacted prior to your admission date by a registered nurse who may ask for more information. This is to assist with planning your care while you are in hospital.

HOSPITAL USE ONLY

DISCHARGE PLANNING

Patient Name: ____________________
Surname *Given names*

Date of Birth: ____________________

Telephone pre-assessment (by admitting nurse)

Date Health Questionnaire reviewed ____________________ Name of RN who reviewed ____________________

Alert Criteria	No	Yes	Details
- More than one regular medication	☐	☐	
- Medical conditions that need further discussion including allergies	☐	☐	
- Need for infection screening	☐	☐	
- Communication barriers	☐	☐	
- Dietary needs	☐	☐	
- Problems with activities of daily living	☐	☐	
- Skin problems (i.e. chronic wounds)	☐	☐	
- Cultural / Spiritual needs	☐	☐	
- Barriers to discharge (i.e. lives alone)	☐	☐	
- Check Blood Tests and ECG completed (Group and Hold)	☐	☐	

Date and time of telephone pre-assessment ____________________

Notes and detailed Action Plan

	No	Yes	Details
Need to get information from outside agency	☐	☐	
Need to refer issues to another member of the mulitdisicplinary team	☐	☐	

Pre-assessment nurse ____________________ Signature ____________________ Date ____________________

Action required by discharge nurse (commenced by admitting nurse)

____
Admitting nurse signature

✓ If action appropriate ✗ If action not required

☐ X-rays returned to patient (as applicable)

☐ Patient's own medications returned

☐ Referrals to other Agencies

☐ ACC / Medical Certificate provided (if applicable)

Other actions taken:

Discharge nurse name ____________________ Signature ____________________ Date ____________________

PRE-OPERATIVE ASSESSMENT

(Anaesthetist to complete this page)

NAME

PROPOSED PROCEDURE

BOOKING DATE AM PM

SURGEON

ASSESSED BY DATE

HISTORY

Good Health Yes No

Good Exercise Tolerance Yes No N/A

Reflux Yes No

EXAMINATION

AIRWAY

HS

Breath Sounds

BP

P

ASA 1 2 3 4 5 E

Weight ______ Height ______ Body Mass Index ______

CURRENT MEDICATIONS

NIL ☐ See Over ☐

ADVERSE DRUG REACTIONS

NIL ☐ DETAILS

INVESTIGATIONS

PREOP CBC ELECT Urea Cr Gluc LFT ECG G/S XMatch .... CXR

ON ADMISSION CBC ELECT Urea Cr Gluc LFT ECG G/S XMatch .... CXR

ANAESTHETIC PLAN

NBM Orders Confirmed Yes No

OTHER DETAILS

Special Nursing Care required Yes No

PREMEDICATION ORDERS AND ADMINISTRATION DRUG RECORD

DATE	TIME	DRUG	DOSE	ROUTE	DR SIGN	TIME GIVEN	RN SIGN