Health Questionnaire / Nursing Assessment Form

**IMPORTANT** Please deliver, post, fax or email this form **7-10 working days before your admission date** together with the completed Admission and Consent Forms to:

## Wakeﬁeld Hospital Private Bag 7909

***Wellington South 6242***

***Fax (04) 381 8101***

***Email [reception@wakeﬁeld.co.nz](mailto:reception@wakeﬁeld.co.nz)***

### A stamped, addressed envelope is provided.

#### If this is not possible, please make sure you bring the forms with you when you arrive for admission.

**If you faxed or emailed the forms to us, please bring the originals with you.**

Personal Details (patient to complete) Admission Date

**Patient name:**

Mr/Mrs/Ms/Miss/Dr

*Surname*

*Given names*

Preferred Name

Date of birth

Height

Weight

*Known as metres kg*

Previous Surname

Ethnicity

*If applicable*

#### Please bring any x-rays/scans with you when you come to the hospital.

If you are not ﬁlling out this questionnaire for yourself please state the reason why: (eg Parent of a child)

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**Language**

**YES NO COMMENTS**

Is English your ﬁrst language? ...........................................................................................



**Would you like us to arrange an interpreter?** ...........................................................................................

(There is a cost involved)

Will you use a family member as an interpreter?   ...........................................................................................

**Have you had previous surgery or**

**hospital admissions?**

**YES NO COMMENTS**

### If YES, please provide details below

#### Month

and Year Operation/Illness Hospital

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**Do you have or have you ever had**

**YES NO COMMENTS**

High blood pressure ...........................................................................................



Chest pain / angina ...........................................................................................

Heart attack ...........................................................................................

Chest palpitations or irregular heartbeat ...........................................................................................

Heart pacemaker ...........................................................................................

Artiﬁcial heart valves or other heart surgery ...........................................................................................

Rheumatic heart disease ...........................................................................................

Stroke ...........................................................................................

TIAs (mini strokes) ...........................................................................................

Shortness of breath ...........................................................................................

Breathlessness on exertion ...........................................................................................

Swollen ankles ...........................................................................................

Asthma or lung problems If yes, how often do you use your inhaler?........................................

Tuberculosis ...........................................................................................

Diabetes Which type.............................................................................

Jaundice / Liver Disease ...........................................................................................

Kidney problems ...........................................................................................

#### CJD or any neurological disease currently

under investigation   ...........................................................................................

#### A dura mater graft / corneal surgery

prior to 1990   ...........................................................................................

#### Human pituitary derived gonadotrophin or growth



hormone prior to 1990 ...........................................................................................

Blood clots in the legs or lungs ...........................................................................................

Bleeding or bruising problems ...........................................................................................

Anaemia ...........................................................................................

Blackouts or fainting ...........................................................................................

Migraines ...........................................................................................

Epilepsy / ﬁts / seizures ...........................................................................................

A head injury ...........................................................................................

A psychiatric illness ...........................................................................................

**Memory loss and/or confusion** ...........................................................................................

Arthritis / jaw, neck or back problems ...........................................................................................

Joint replacement surgery ...........................................................................................

Muscle or nerve disease ...........................................................................................

Severe snoring / sleep apnoea ...........................................................................................

Severe motion sickness ...........................................................................................

Gastric reﬂux / stomach ulcer ...........................................................................................

HIV / AIDS / Hepatitis ...........................................................................................

Thyroid disease ...........................................................................................

Pituitary problems ...........................................................................................

Treatment for cancer ...........................................................................................

History of eczema, skin conditions ...........................................................................................

**MRSA / VRE ESBL** ...........................................................................................

**Employment in a health facility within the last 6 months** ...........................................................................................

**General Anaesthetics**

**YES NO COMMENTS**

Have you ever had a general anaesthetic?   ............................................................................................

Any problems / side effects, complications If yes please explain

following a general anaesthetic?   ............................................................................................

### Do you have any concerns about your anaesthetic

**that you would like to discuss with your Anaesthetist?  ** ............................................................................................

If you need more space please attach the additional information on a separate piece of paper

**Medications**

It is important that you list **all medications** you are taking, including natural (alternative) and complementary medications. **Please bring all medications into hospital in the original containers. If your medicines are in “Blister Packs”, please provide a medicine list from your pharmacist or General Practitioner.**

### Medication Dose or Number of times Reason for medication

(drug name on packet) **strength taken each day** (if known)

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**Allergies and Sensitivites**

**YES NO COMMENTS**

Are you allergic / sensitive to any: ***If YES, please name the item and describe the reaction***



**Medications** ............................................................................................



**Foods** ............................................................................................

**Plasters and tape** ............................................................................................

**Latex** ............................................................................................

**Other** ............................................................................................

**General Questions**

**YES NO COMMENTS**

Do you smoke? If yes, how many per day?............................................................



Did you ever smoke? If yes, what year did you stop?.......................................................

Do you drink alcohol? Average weekly intake ................................................................

### Females: is there a possibility you might be pregnant? (X-rays during surgery or anaesthetic

**drugs may cause harm to your baby)  ** ............................................................................................

### Do you presently have any cuts, scratches, sores

**or abrasions on your skin?  ** Location..................................................................................

#### Do you have a family history of:



– **Anaesthetic reactions** ............................................................................................

– **Bleeding disorders** ............................................................................................

#### – Other neurological illness currently under

investigation   ............................................................................................

#### Do you have any concerns about your hospital stay

that you would like to discuss with us?   ............................................................................................

**Dietary Needs**

**YES NO COMMENTS**

**Do you have special dietary needs?** ............................................................................................



**Cultural Care**

**YES NO COMMENTS**

### Do you have any cultural needs we should

**be aware of?  ** ................................................................................

### Would you like us to return any surgically

**removed body parts or metalware?  ** ................................................................................

**Spiritual Care**

**YES NO COMMENTS**

*The inter-denominational hospital chaplain visits as part of Wakeﬁeld’s spiritual care*

Would you like to be visited by the hospital chaplain?   ................................................................................

#### Would you like a visit from a minister/priest

of your own faith?   ................................................................................

**Activities of Daily Living**

**YES NO COMMENTS**

Do you have any restricitions with mobility? ...............................................................................



**Have you had any falls in the last 6 months?** ...............................................................................

Do you use any mobility aids eg crutches? ...............................................................................

Do you have any stairs at home? ...............................................................................

Do you have any problems with speech? ...............................................................................

Do you have any problems with vision? ...............................................................................

Do you have any problems with hearing? ...............................................................................

Do you need assistance with toileting? ...............................................................................

Do you need assistance with showering? ...............................................................................

Do you need assistance with dressing? ...............................................................................

**Discharge arrangements you have made**

**YES NO COMMENTS**

Are you going to your own home on discharge? ................................................................................



Someone to stay with you on the night of discharge? ................................................................................

Someone to drive you home? ................................................................................

Do you have dependants at home? ................................................................................

#### Do you anticipate any problems on discharge?

If yes, please explain   ................................................................................

**Do you currently receive assistance or have**

**you arranged any Community Services?**

**YES NO COMMENTS**

ACC Home Care ................................................................................



Home Help services ................................................................................

District Nurses ................................................................................

Other ................................................................................

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

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Do you wish to proceed with the surgery **YES NO ** Would you like us to **YES NO **

#### your surgeon has discussed with you? phone you after discharge?

**Patient/Guardian**

*Signature*

*Date*

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**NOTE:** If within 7 days prior to your admission you have any of the following: ﬂu, cold, broken or infected areas of the skin, vomiting/ diarrheoa – **please contact your surgeon**.

**FOR HOSPITAL USE ONLY** (prior to admission)

Phone Pre-assessment YES  NO  Date Pre-assessed Anaesthetic Issues:

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#### Medical History:

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#### Medications:

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#### Other:

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**YES NO COMMENTS**

Sensitivites: on TRAK   .......................................................................................

Allergies: On TRAK   .......................................................................................

Needs conﬁrmation with patient   .......................................................................................

#### Alerts: On TRAK

Medical staff informed   .......................................................................................

#### Request for information from other

Health Providers   From................................................................................

.......................................................................................

### Pre-assessment Nurse

*Signature*

*Date*

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**FOR HOSPITAL USE ONLY**

Admission Assessment

**Action required by admitting nurse** (after reviewing questionnaire with patient)

#### v'If action appropriate KIf action not required

 Discuss possible need for night special if patient has known history of confusion / memory loss

 MRSA swabs if patient admitted overnight to (or employed in) a hospital or rest home in last 6 months

 ESBL swab if patient has been admitted for more than 2 days to (or employed in) a hospital or rest home in last 6 months  Anaesthetist notiﬁed of any issues or concerns

 Patients own medications locked in ward drug room / safe  Pharmacist required to check medication blister packs

 Theatre notiﬁed of a latex allergy or patient weight >100kgs  Allergies and alerts updated in TRAK

 Skin assessment completed

 Wound assessment chart commenced

 Dietary requirements / food allergies updated in TrendCare  Physiotherapist referral for mobility risk assessment

**Day Case patients only**

 Transport home has been arranged ie: not driving self home or catching a bus  There will be a responsible person at home with patient overnight Other actions taken:

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# Discharge Planning

**Action required by discharge nurse** (commenced by admitting nurse)

#### v'If action appropriate KIf action not required

 X-rays to be returned to patient (except CCDHB contracts)

#### Referrals to other Agencies will be required Patient’s own medications to be returned

 A phone follow up is requested by the patient ACC/Medical Certiﬁcate will be required on discharge



Other actions taken:

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**Admitting Nurse**

*Signature*

*Date*

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