

# Health Questionnaire



WAKEFIELD  
HOSPITAL

## Important!

Please deliver, post, or email this form 7–10 working days before your admission together with the completed Admission, Finance and Consent Form to:

Wakefield Hospital  
Private Bag 7909  
Wellington South 6242  
  
Email: [reception@wakefield.co.nz](mailto:reception@wakefield.co.nz)

A stamped, addressed envelope is provided for posting.  
If this is not possible, please make sure you bring the forms with you when you arrive for admission. If you emailed the forms to us, please bring the originals with you.

## Personal Details (patient to complete)

Admission Date:

**Personal details:**

Mr/Ms/Mrs/Miss/Dr

First name

Middle name

Surname

Preferred Name

Date of birth

Age

NHI No:

Known as

If known

Gender

Ethnicity

Are you: NZ Citizen

Permanent resident

Email

Telephone

Home

Work

Mobile

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

Cardiac	YES	NO	COMMENTS
High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Have you ever had any problems with your heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Chest pain or discomfort? Angina?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Have you ever had a heart attack?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Palpitations or irregular heartbeat?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Any procedures, operations or investigations on your heart: surgery, stents, heart valve replacement, or an Implanted cardiac defibrillator (ICD) or Pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Do you have any problems with your circulation or ever had any operations on your veins or arteries?	<input type="checkbox"/>	<input type="checkbox"/>	.....

Respiratory	YES	NO	COMMENTS
Asthma or chronic airways disease (COPD)?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Any other lung or breathing problems?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Chest infections?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Have you had a chest infection in the last four weeks and did it require steroids/medication to treat? Please provide details if yes.	<input type="checkbox"/>	<input type="checkbox"/>	.....
Loud snoring (that can be heard from other rooms)?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Sleep apnoea (or have you been told you stop breathing while asleep?)	<input type="checkbox"/>	<input type="checkbox"/>	.....
Do you use a CPAP machine?	<input type="checkbox"/>	<input type="checkbox"/>	.....

Endocrine (glands), hormonal disorders and diabetes		YES	NO	COMMENTS
Diabetes?		<input type="checkbox"/>	<input type="checkbox"/>	Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/>
Do you currently use:	Insulin <input type="checkbox"/> Tablets <input type="checkbox"/> Diet control <input type="checkbox"/>			Please bring blood sugar recordings with you if available.
Any other endocrine, hormone or gland problems?	<input type="checkbox"/>	<input type="checkbox"/>		.....
Thyroid problems?	<input type="checkbox"/>	<input type="checkbox"/>		.....
Adrenal or pituitary problems?	<input type="checkbox"/>	<input type="checkbox"/>		.....

Kidney and urinary systems		YES	NO	COMMENTS
Kidney (renal) condition? (e.g. only one kidney, dialysis)	<input type="checkbox"/>	<input type="checkbox"/>		.....
Kidney stones?	<input type="checkbox"/>	<input type="checkbox"/>		.....
Urinary problems? (e.g. Recurrent infection, bed wetting.)	<input type="checkbox"/>	<input type="checkbox"/>		.....
Any other kidney or urinary problems?	<input type="checkbox"/>	<input type="checkbox"/>		.....

Neurological		YES	NO	COMMENTS
Do you have any problems or under treatment for any neurological condition?	<input type="checkbox"/>	<input type="checkbox"/>		.....
Stroke, Cerebrovascular accident (CVA), or Transient Ischaemic Attack or (TIA)	<input type="checkbox"/>	<input type="checkbox"/>		.....
Seizures, blackouts or fainting relating to epilepsy? If yes, how often do you have seizures? When was the last time?	<input type="checkbox"/>	<input type="checkbox"/>		.....
Dementia or cognitive problems? (Alzheimer's, forgetfulness)	<input type="checkbox"/>	<input type="checkbox"/>		.....
Paraplegia or spinal problems?	<input type="checkbox"/>	<input type="checkbox"/>		.....
Muscle or Neurological disease e.g. MS, Parkinson's, Muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>		.....
CJD or any neurological disease currently under investigation?	<input type="checkbox"/>	<input type="checkbox"/>		.....

Liver		YES	NO	COMMENTS
Hepatitis A, B, C, jaundice or liver condition?	<input type="checkbox"/>	<input type="checkbox"/>		.....
Cirrhosis?	<input type="checkbox"/>	<input type="checkbox"/>		.....
Gallstones?	<input type="checkbox"/>	<input type="checkbox"/>		.....
Any other problems?	<input type="checkbox"/>	<input type="checkbox"/>		.....

Blood disorders		YES	NO	COMMENTS
Blood clots in lungs or legs? (PE, DVT, thrombosis?)	<input type="checkbox"/>	<input type="checkbox"/>		.....
Bleeding disorder and/or family history (von Willebrands disease/hemophilia)	<input type="checkbox"/>	<input type="checkbox"/>		.....
Anaemia?	<input type="checkbox"/>	<input type="checkbox"/>		.....
Previous blood transfusion? If yes, when was the last, and what was the reason?	<input type="checkbox"/>	<input type="checkbox"/>		.....

Gastrointestinal	YES	NO	COMMENTS
Gastric reflux or hiatus hernia?	<input type="checkbox"/>	<input type="checkbox"/>	.....
If yes, is your heartburn well controlled?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Please provide details.			.....
Any other gastrointestinal issues or procedures?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Inflammatory bowel disease e.g. Crohns or Ulcerative Colitis?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Diverticular disease?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Any surgery on your bowels or stomach?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	.....

Bones and joints	YES	NO	COMMENTS
Arthritis/Rheumatoid arthritis?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Joint replacement or orthopaedic metalware?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Other issues?	<input type="checkbox"/>	<input type="checkbox"/>	.....

Skin	YES	NO	COMMENTS
Do you have any eczema/skin conditions?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Do you currently have any cuts, scratches, sores or abrasions on your skin?	<input type="checkbox"/>	<input type="checkbox"/>	.....

Infection	YES	NO	COMMENTS
Are you a healthcare professional or have you stayed in hospital during the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Travelled overseas in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	.....
If so, where and were you hospitalised?			.....
Transmittable diseases e.g. Hepatitis B or C, Tuberculosis, or HIV?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Have you ever had a drug resistant infection? (MRSA, VRE, ESBL, VRSA)	<input type="checkbox"/>	<input type="checkbox"/>	.....
Have you had a blood transfusion in Europe 1980-1996 or a human tissue transplant prior to 1992?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Have you received human pituitary gonadotrophin or growth hormone prior to 1990?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Have you had COVID-19? (Coronavirus). If yes, are you under any treatment or monitoring for this condition?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Have you had or been in contact with someone with COVID-19? (Coronavirus). If so when?	<input type="checkbox"/>	<input type="checkbox"/>	.....

Mental health and wellbeing	YES	NO	COMMENTS
Do you suffer from anxiety, depression, PTSD or emotional disturbance or phobias e.g. needles?	<input type="checkbox"/>	<input type="checkbox"/>	.....

Chronic pain	YES	NO	COMMENTS
Do you have any chronic pain issues? If yes, what is the location of the pain? How is this being managed?	<input type="checkbox"/>	<input type="checkbox"/>	.....

Other	YES	NO	COMMENTS
-------	-----	----	----------

Have you ever been investigated or treated for cancer?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Is there any other relevant medical condition you need to tell us about?	<input type="checkbox"/>	<input type="checkbox"/>	.....

Allergies, adverse reactions and food intolerances	YES	NO	Please describe the reaction
--	-----	----	------------------------------

Do you have a latex allergy?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Other allergies	<input type="checkbox"/>	<input type="checkbox"/>	.....
Adverse reactions e.g. medications or medical products	<input type="checkbox"/>	<input type="checkbox"/>	.....
Food intolerances	<input type="checkbox"/>	<input type="checkbox"/>	.....

Medications
-------------

Please list all medications you currently take including the dose and how often you take the medication in a day. This includes tablets, injections, contraceptive pills, inhalers, puffers, eye drops, patches etc. Alternatively, if your pharmacist provides you with a pre-filled multi-pack, ask for a printout of the medications you are currently taking. Please also include over-the-counter and any complementary, herbal, homeopathic or other alternative therapies.

Name	Dose	When do you take your medication?	Why do you take the medication?
.....			
.....			
.....			
.....			

Health professionals
----------------------

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

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

Previous surgery/anaesthesia	YES	NO
------------------------------	-----	----

Have you ever had surgery or been admitted to hospital before?	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------

Operation/illness	Year	Hospital
.....		
.....		
.....		

Anaesthesia related issues	YES	NO	Please describe the reaction
----------------------------	-----	----	------------------------------

Do you have or have you ever had any of the following? If 'yes' or if you are uncertain, please comment in the box.

Have you ever had any problems with a previous surgery or recovery?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Do you have any jaw or neck problems?	<input type="checkbox"/>	<input type="checkbox"/>	.....
If yes, do you have any difficulty opening your mouth wide?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Do you have any restrictions in your head or neck movement?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Do you have any jaw problems e.g. jaw locking?	<input type="checkbox"/>	<input type="checkbox"/>	.....

Anaesthesia related issues cont.	YES	NO	Please describe the reaction
Have you been told you are difficult to intubate?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Are there any conditions that run in your family? (e.g. malignant hyperthermia, thalassaemia, muscular dystrophy?)	<input type="checkbox"/>	<input type="checkbox"/>	.....
Have you had any problems while under an anaesthetic? (e.g. slow to wake, nausea and vomiting, post surgery confusion, agitation)	<input type="checkbox"/>	<input type="checkbox"/>	.....
Has any blood relative had problems while under an anaesthetic?	<input type="checkbox"/>	<input type="checkbox"/>	.....

Dietary needs

The nurse will ask you for more information on any dietary requirements you may have.

	YES	NO						
Do you have any dietary requirements?	<input type="checkbox"/>	<input type="checkbox"/>						
Please check any dietary requirements you have:								
Gluten free	<input type="checkbox"/>	Dairy free <input type="checkbox"/>	Lactose free <input type="checkbox"/>	Pescatarian <input type="checkbox"/>	Vegetarian <input type="checkbox"/>	Vegan <input type="checkbox"/>	Keto <input type="checkbox"/>	FOD map <input type="checkbox"/>
Other	<input type="text"/>							

Fitness and lifestyle

How would you describe your general health?	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>
Do any symptoms limit your ability to exercise? E.g. breathlessness, chest pain, pain in joints, leg pain.	YES <input type="checkbox"/>	NO <input type="checkbox"/>	.....
Have you ever smoked?	YES <input type="checkbox"/>	Ex smoker <input type="checkbox"/>	Never <input type="checkbox"/>
Do you currently smoke tobacco, eCigarettes or vape? If yes, please provide details e.g. how many per day?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	.....
Do you smoke recreational drugs? If so, what and how often?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	.....
Do you drink alcohol regularly? If yes, how many units per week?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	.....
Are you or do you think you may be pregnant? If yes, how many weeks?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	.....

Communication and culture	YES	NO	Comments
Do you have a visual or hearing impairment?	<input type="checkbox"/>	<input type="checkbox"/>	Hearing aids or glasses? .....
Do you have any cultural needs we should be aware of?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Do you speak English fluently? <i>If an external interpreter service is required, this will incur an additional cost.</i>	<input type="checkbox"/>	<input type="checkbox"/>	If no, which language?.....
Blood transfusions: Do you have any reasons which might stop you from accepting a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Human tissue: Would you like surgically removed body parts to be returned? (Excludes metalware)	<input type="checkbox"/>	<input type="checkbox"/>	.....

Discharge planning	YES	NO	Comments
--------------------	-----	----	----------

To help the nurses plan your discharge home after your operation, we need to ask you a few general questions.

Do you require any physical support or aids?  
If so, what?

☐
☐

.....

Do you live alone?  
If yes, and your surgery is booked as a day case,  
have you arranged for an adult to take you home and  
stay with you overnight? If yes, please give detail.

☐
☐

.....

Do you have any dependents?

☐
☐

.....

Do you have any pets?

☐
☐

.....

Do you have any problems with daily activities?  
Can you manage around the house? With or without  
mobility aids? (e.g. showering, bathing, dressing)

☐
☐

.....

Do you have stairs at home?

☐
☐

.....

Have you had a fall in the last 6 months?

☐
☐

.....

Will someone be taking you home?

☐
☐

.....

Do you have someone to stay overnight with you  
when you get home?

☐
☐

.....

Are you currently using any community support  
services? If so, please list.

☐
☐

.....

Do you have any other concerns about your discharge?

☐
☐

.....

Do you have a disability we should be aware of?

☐
☐

.....

What is the best contact number to reach you on  
following the first few days after your discharge?

.....