Waitemata
District Health Board
Best Care for Everyone

[PLACE PATIENT LABEL HERE]

First Name: _____ Gender: _____
Surname: _____
Address: _____
Date of Birth: _____ NHI#: _____
Ward/Clinic: _____ Consultant: _____

Date: _____ GP Name: _____ GP Number: _____

Self Assessment Form

Proposed operation? _____ Questionnaire seen by [print name] _____
_____ Date _____
_____
_____

A No appointment required ☐ B Short appointment ☐ C Long appointment ☐
Other – please state _____ Interpreter [language] needed? _____

WT _____ Height _____ BMI _____ BP _____ Pulse _____ SpO2 [air] _____

HEALTH QUESTIONNAIRE

If you are fit and healthy but wish to see an anaesthetist in clinic rather than just before your operation, please tick here. ☐

PLEASE READ CAREFULLY and answer all the questions as accurately as you are able. Our staff will be happy to help you with any questions you may have. This form is part of your health assessment prior to surgery. It will not influence your priority on the waiting list and will be dealt with in strict confidence.

GENERAL HEALTH – Below is a list of medical conditions that commonly affect peple coming to this hospital for operations. Do any apply to you? Please read through this list carefully and **circle yes or no in answer to each question**. Use the space on page 4 if necessary.

High Blood Pressure	Y	N	Asthma	Y	N	Diabetes	Y	N
Chest Pains	Y	N	Bronchitis	Y	N	Thyroid Disease	Y	N
Angina Pain	Y	N	Persistent Cough	Y	N	Rheumatoid Arthritis	Y	N
Chest Heaviness	Y	N	Emphysema	Y	N	Kidney Problems	Y	N
Shortness of Breath	Y	N	Sleep Apnoea	Y	N	Deep Venous Thrombosis or Embolus	Y	N
Rheumatic Fever	Y	N	Heartburn	Y	N	Bleeding Disorder/Easy Bruising	Y	N
Heart Attack	Y	N	Acid Reflux	Y	N	Depression	Y	N
Heart Murmur	Y	N	Severe Indigestion	Y	N	Panic Attacks	Y	N
New Heart Valve	Y	N	Stroke	Y	N	Severe Anxiety	Y	N
Heart Pacemaker	Y	N	Fits/Convulsions	Y	N	Any Mental Illness	Y	N
Palpitations	Y	N	Blackouts/Funny Turns	Y	N	Severe Back/Neck Pain	Y	N

Do you have any other medical conditions not already mentioned? _____
_____
_____

Self Assessment Form

5.4.005

MEDICINES

Which medicines do you take including herbal and alternative medicines? **Please list ALL medicines** (use the space on page 4 if necessary) **and bring a list of your medicines with you any time you come to clinic.**

Medicine Name	Dose	How often, for how long?

ALLERGIES – Are you allergic to any medicines, foods, latex, dressings, etc?

Please Circle Yes No

What are you allergic to?	What happens?

Use the space on page 4 of this form if necessary

HABITS – Please circle answers that apply

Please include all information, this form is strictly confidential

Do you smoke?	Y	N	How many each day? _____
Ex smoker?	Y	N	How long ago did you stop? _____
Do you drink alcohol?	Y	N	How much, how often? _____
Do you take non-prescription drugs?	Y	N	Which drug, how often? _____

ACTIVITY LEVEL AND LIFESTYLE – Please circle answers that apply

I am very fit and active **Yes** **No**

If NOT very fit and active, which of the following CAN you do? Please tick those activities that you CAN do comfortably without stopping.

Wash and dress unaided	Y	N	Climb two flights of stairs	Y	N
Walk 50 metres on the flat	Y	N	Carry shopping bags up two flights of stairs	Y	N
Walk 500 metres on the flat	Y	N	Walk up a steep hill	Y	N

HOSPITAL ADMISSIONS AND OPERATIONS

Please give details of any hospital admissions and/or operations, most recent first. Include type of anaesthetic (local, general, spinal, epidural) if known. **Continue on page 4 if necessary.**

Date	Place	Details

ANAESTHESIA HISTORY

Have you or a member of your immediate family (parents, brothers and sisters) ever had a bad reaction to anaesthesia or been told that you have an inherited (it 'runs in the family') reaction to anaesthetic?

Yes No

Person	Reaction to Anaesthesia

Do you have any problems with back pain, limited neck movement, limited mouth opening, loose or irregular teeth? Yes No

If yes – please explain:

CLINIC NOTES

USE THE NEXT TWO SECTIONS TO GIVE FURTHER INFORMATION IF NEEDED.
PLEASE SIGN AT THE BOTTOM OF THE PAGE.

GENERAL HEALTH, MEDICINES AND ALLERGIES – FURTHER INFORMATION

HOSPITAL ADMISSIONS AND OPERATIONS – FURTHER INFORMATION

If you have any special needs, questions or concerns about your anaesthetic, please ask to speak to the nurse.

Patient's Name: _____

Patient's Signature: _____

Interpreter's Name: _____

Interpreter's Signature: _____