

A



**Patient to complete A, B & C and return to the hospital
PRIOR TO ADMISSION to confirm your booking**

Admissions, PO Box 31459, Lower Hutt
666 High Street, Lower Hutt 5040
Phone: 569-7555 • Fax: 567-0041

Surname Given Names Mr/Mrs/Ms/Miss/Master
Date of Birth Age Sex: M/F Ethnicity(optional)
Address Postcode
Telephone (H) (Bus) (Mobile)
Family Doctor NHI No (if known)

Emergency Contact Name Relationship
Address
Telephone (Day) (A/h)

Type of Accommodation: Single Room Double Room Short Stay Parent Rooming in

Special Dietary Requirements (please state)

Any other special needs – physical/cultural/spiritual/communication (please state)

Procedure:

Surgeon: **Admission Date:**

Have your hospital treatment costs been approved by:

ACC: YES / NO If so, ACC No:

Medical Insurance: Policy No: Approval No:

Name of Company:

Payment will be made by: (please tick) Credit Card Cheque Cash Eft Pos

All costs are an APPROXIMATION only

HOSPITAL ADMINISTRATION ONLY

Consent form checked Y N
Anaesthetist advised Y N
Hospital advised Y N
Hospital Notes/X-ray files available Y N/A

Admission Clerk Principal Nurse
(Signature) (Signature)

**A
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B

It is important that you answer all questions as accurately as possible. All information is sought to minimise your risk and will be retained as part of your confidential clinical records.

• Do you suffer from, or have you ever suffered from, the following?

- | | | | |
|---|-------|--------------------------------------|-------|
| Chest pains/tightness or Angina | Y / N | Shortness of breath | Y / N |
| Previous Rheumatic Fever | Y / N | Asthma | Y / N |
| Previous Heart Attack | Y / N | Emphysema or Bronchitis | Y / N |
| Palpitations | Y / N | Tuberculosis | Y / N |
| Heart Murmur | Y / N | Obstructive Sleep Apnoea | Y / N |
| High Blood Pressure | Y / N | Persistent Cough | Y / N |
| Artificial Heart Valve or Pacemaker | Y / N | Stroke or Seizures | Y / N |
| Hiatus Hernia/Heartburn/Indigestion | Y / N | Jaundice or Hepatitis | Y / N |
| Diabetes | Y / N | Please specify type (if known) | |
| Insulin <input type="checkbox"/> Oral Medication <input type="checkbox"/> | | Kidney Disease | Y / N |
| Diet Controlled <input type="checkbox"/> | | Thyroid Disease | Y / N |
| Rheumatoid Arthritis | Y / N | Previous DVT or Lung Embolus | Y / N |
| HIV/Aids | Y / N | Prostate Conditions | Y / N |

Your Weight:kg

Your Height:metres

Do you:

Smoke: Y / N How many?

Drink Alcohol: Y / N How much?

How often?

Are you at risk of exposure to Hepatitis: Y / N

• If you have answered yes to any of the above or have any other illness, please give further details below.

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• Please list previous hospital admission including year and hospital (if known).

| Reason for admission | Date | Hospital |
|----------------------|-------|----------|
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• What medications (including herbal)/drugs are you taking?

| Medication | Dose | Time Taken |
|------------|-------|------------|
| | | |
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| | | |

Patient ID



- **Do you have problems opening your mouth?** YES/NO
- **Have you been told of previous problems with your airway under anaesthesia?** YES/NO
- **Do you have any of the following:** (please tick those that apply)
 - dentures partial plate capped or loose teeth
- **What physical activity(ies) do you take part in on a regular basis?** (please tick those that apply)
 - walking gym work tennis golf others (list) _____
- **I can climb** one two or more flights of stairs without getting short of breath.
- **My activity is restricted by:** (please tick those that apply)
 - shortness of breath chest pain joint pain
- **Women only – Are you, or could you, be pregnant?** YES/NO

| SUBSTANCE | | TYPE OF REACTION | YES/NO |
|-----------|-------|------------------|--------|
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- **Are there any major illnesses, to your knowledge, within your blood relatives eg; diabetes, muscular dystrophy, malignant hyperthermia etc?** If so, please outline YES/NO

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- **Have you been in any other hospital/resthome in the last 6 months?** YES/NO
- **Have you ever previously cultured MRSA?** YES/NO
- **Have you or any of your family had problems with anaesthetic?** If so, please outline YES/NO

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- **Do you suffer from any other conditions, not covered elsewhere, that you feel we should know about?** If so, please outline YES/NO

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- **Do you have any concerns or questions about your anaesthetic?** If so, please outline YES/NO

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The details above have been completed by: [PLEASE SIGN BELOW]

patient guardian relative or other? (please tick)

Signed: **Date:**

To be completed upon admission

Has there been any change in your health since completing the questionnaire? YES/NO

Have you been well in the past month? If not, please outline changes or health problems.

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Patient ID