

**Patient pre-operative Assessment Questionnaire**

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| Patient name |  | | Hospital Number | |  | | | |
| Address | | | | | | | | |
| Are you fluent in English | | Yes / No | Date of Birth |  | | | | |
| Landline Contact number | |  | Mobile Contact number | | |  | | |
| Email Address |  | | | | | | | |
| |  | | --- | | Are you happy for us to send you information about your surgery/admission via email? | | | | | | | | Yes | No |

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| Do you have any of the following? | | | **Yes** | **No** |  | | | | | **Yes** | **No** |
| **Heart or Blood Pressure conditions** | | | | | | | | | | | |
| High Blood Pressure | | |  |  | Chest Pain or discomfort / Angina | | | | |  |  |
| Irregular Heart beat | | |  |  | Heart Murmur / Rheumatic fever | | | | |  |  |
| Heart Attack | | |  |  | Heart Surgery / Stents / Pacemaker / ICD | | | | |  |  |
| Cardiomyopathy / Heart Failure | | |  |  | Black outs / Fainting | | | | |  |  |
| **Lung Conditions** | | | | | | | | | | | |
| Asthma Yes / No (If yes, please answer 2 questions below) | | | | | | | | | | | |
| Have you taken steroids in the last 3 months? | | |  |  | Have you ever been hospitalised with your asthma/ | | | | |  |  |
| Sleep apnoea / CPAP or do you snore heavily / have you been told you stop breathing in your sleep? | | | | | | | | | |  |  |
| COPD or Emphysema | | |  |  | If yes: are you on home oxygen? | | | | |  |  |
| Bronchitis Yes / No (If yes, please answer 2 questions below) | | | | | | | | | | | |
| Can you do all of your normal activities without getting out of breath? | | |  |  | Do you have recurrent chest infections? | | | | |  |  |
| Any other respiratory issues? | | |  |  |  | | | | |  |  |
| **Gland or Joint conditions** | | | | | | | | | | | |
| Thyroid problems | | |  |  | Diabetes | | | | |  |  |
| Rheumatoid Arthritis | | |  |  | Joint replacement or orthopaedic metalwork | | | | |  |  |
| Jaw / Head or mouth opening problems | | |  |  |  | | | | |  |  |
| Brain or Nervous System conditions | | | | | | | | | | | |
| Seizures / Fits / Epilepsy | | |  |  | Stroke (CVA / TIA) | | | | |  |  |
| Do you suffer from Anxiety / depression or mental illness? | | | | | | | | | | | |
| **Muscle / Neurological conditions** | | | | | | | | | | | |
| Multiple Sclerosis | | |  |  | Parkinson’s | | | | |  |  |
| Muscular dystrophy | | |  |  | Dementia (Alzheimer’s / forgetfulness) | | | | |  |  |
| Any other Cognitive Impairment | | | | | | | | | |  |  |
| **Other** | | | | | | | | | | | |
| Anaemia / Low Iron | | |  |  | Bleeding or Clotting disorder | | | | |  |  |
| Sickle Cell Disease or trait | | |  |  | Previously blood clot in legs or lungs | | | | |  |  |
| Kidney / renal conditions | | |  |  | Liver conditions / Jaundice | | | | |  |  |
| MRSA | | |  |  | HIV / TB / HEP B or C | | | | |  |  |
| Have you ever been notified that you are at risk of Creutzfeldt-Jacob Disease for public health purposes? | | | | | | | | | |  |  |
| Do you have a severe hearing impairment | | |  |  | Do you have a severe sight impairment | | | | |  |  |
| Is there any other relevant medical information that you need to tell us about? | | | | | | | | | |  | |
| **Fitness / Lifestyle** | | | | | | | | | | | |
| What is your Height? (cm) | | |  |  | What is your weight? (kg) | | | | |  | |
| How many flights of stairs can you walk without stopping to rest **( Please tick answer below)** | | | | | | | | | | | |
| More than 2 flights |  | | 1-2 flights | |  | | Less than 1 flight | | |  | |
| If less than 1 flight: What is your reason for stopping? | | | | | | | | | | | |
| Are you a: Smoker |  | How many per day | | |  | Non Smoker | |  | Ex-smoker (>1 year) | |  |
| Do you drink alcohol | | |  | Over 30 unites per week | | | |  | Rarely | |  |
| Do you use any recreational drugs | | |  |  | Are you allergic to any medication / food / latex etc. (causes itching / swelling / anaphylaxis? | | | | |  |  |

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| Please list any regular medications that you take |  | Have you had any admissions to hospital for major illness or operation |  |
| Medication Name | Dose | Details | Year |
|  |  |  |  |

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| --- | --- | --- | --- | --- | --- |
| **Previous Anaesthesia** | Yes | No |  | Yes | No |
| Have you had General anaesthetic before |  |  | If yes: have you had any problems while under general anaesthetic |  |  |
| Has any blood relative had problems while under general anaesthetic (not including feeling sleepy afterwards or nausea / vomiting) | | | |  |  |
| Is there any history of Malignant hyperthermia in your family |  |  | Is there history of Suxamethonium apnoea in your family |  |  |
| Do you have heartburn / reflux of acid / hiatus hernia? | | | |  |  |
| **Discharge planning** | | | | | |
| Do you currently require any physical support or aids |  |  | Do you live alone |  |  |
| Do you have any problems with daily activities |  |  | Are you currently using any community support services |  |  |

Patient declaration

I confirm the health information I have provided is a true and accurate account of my health status.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for completing your questionnaire.