

SURNAME: _____ NHI: _____
 FIRST NAMES: _____
 DATE OF BIRTH: _____ / _____ / _____ SEX: _____
 Please attach patient label here

**Pre-Assessment Health Questionnaire
To be completed by patients**

This information is important and confidential. Please complete both sides of this form fully.
If you need help to complete this form or need an interpreter, please ask a staff member.

Are the above name and details correct? _____
 What you like us to call you (i.e. Mr or Mrs or by your first name)? _____
 Do you require an Interpreter? Yes No Language _____
 Do you have any particular cultural/religious needs? _____
 Do you have any difficulties with speech, hearing or vision? _____
 What operation will you be having? _____

For Day Surgical patients only:

Will you have someone to take you home by car? Yes No
 Will you have a responsible adult to look after you overnight? Yes No

Health Questionnaire Do you suffer from, or have you ever suffered from, the following:

	Yes	No		Yes	No		Yes	No
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema or bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Stroke / TIA	<input type="checkbox"/>	<input type="checkbox"/>
Previous heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough	<input type="checkbox"/>	<input type="checkbox"/>	Blackouts / Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Medication for long term pain	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations or unusual beating	<input type="checkbox"/>	<input type="checkbox"/>	Obstructive Sleep Apnoea	<input type="checkbox"/>	<input type="checkbox"/>	Recreational Drugs	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve or pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Anaemia	<input type="checkbox"/>	<input type="checkbox"/>	Steroids (e.g. Prednisone)	<input type="checkbox"/>	<input type="checkbox"/>
Chest pains / Tightness or angina	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding or excessive bruising	<input type="checkbox"/>	<input type="checkbox"/>	Joint or metal implant	<input type="checkbox"/>	<input type="checkbox"/>
How often _____			Blood clots in lungs/legs	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
When did it last occur _____			Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke	<input type="checkbox"/>	<input type="checkbox"/>
Hiatus hernia/Heartburn/Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis / Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	How many daily _____		
Previous rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Are HIV+ or have AIDS	<input type="checkbox"/>	<input type="checkbox"/>	If you stopped, when _____		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcohol	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much _____		
			Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	How often _____		

Women Only. Are you or could you be pregnant? Yes No If yes, how many weeks _____
 I had surgery on my brain or spinal cord prior to 1992 Yes No
 I received pituitary - derived hormones for infertility or short stature prior to 1985 Yes No
 I was involved in a CJD surgical instrument contact incident. Yes No

If you answered "yes" to any of the above, please give further details below:

Please list all previous admissions to hospital/Consultation with private specialist

Reason for admission	Hospital	Date
		/ /
		/ /
		/ /
		/ /



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Pre-Assessment Health Questionnaire

Please list all current medications (including natural remedies / complementary therapies)

Drug name	Dose	Times of Day Taken

Do you have any allergies to medication, tablets, plasters, food, LATEX or any other substance Yes No

If "Yes", please list

Substance	Type of reaction

Do you have a problem opening your mouth? (e.g. previous jaw problems) Yes No

Have you been told of any difficulties during previous anaesthetics? Yes No

Do you have dentures, partial plate, capped or loose teeth? Yes No

Does lying flat make you breathless? Yes No

How many pillows do you sleep with at night? _____

What physical activities do you take part in on a regular basis? Please tick those that apply.

Walking Gym work Tennis Golf Other (specify) _____

How many flights of stairs can you climb without getting out of breath?

One flight Two flights Three flights or more

My activity is restricted by: Shortness of breath Chest pain Joint pain Muscle pain Not applicable

Are there any major illnesses, to your knowledge, among your blood relatives?

e.g. diabetes, muscular dystrophy, malignant hyperthermia Yes No If "Yes", please list

Have you or any of your family had problems with an anaesthetic? Yes No If "Yes", please outline

Do you suffer from any other conditions (including mental health) not already noted or do you wear a medic alert bracelet?

Yes No If "Yes", please outline

Do you have any concerns or questions about your anaesthetic or surgery?

The details above have been completed by patient / guardian / relative / other (please circle)

Signed: _____ Date: ____ / ____ / ____

Staff to complete

Height:	cm	Weight:	Kg	BMI:	kg/m ²
BP:		HR:		O ₂ Sats (air)	
To see GP for blood pressure control:	<input type="checkbox"/>			Peak flow	ℓ/min

PRE ASSESSMENT HEALTH QUESTIONNAIRE

CR2049