PRE-OP HEALTH QUESTIONNAIRE

Patient Sticker	Please confirm the details on this label are correct. yes ☐
	Height _____ cm Weight _____ kg

Please complete both sides of this questionnaire:

HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING

Please tick Yes or No. If yes please circle appropriate condition: eg (Angina) / Chest pain **Yes** ☑ **No** ☐

	Yes	No		Yes	No
High blood pressure / Low blood pressure			History of dura mater implants prior to 1992		
Angina / Chest Pain / Palpitations			Past exposure to human-derived Growth Hormone		
Previous heart attack / coronary surgery					
How long ago?			History of neurosurgery prior to 1992		
Heart Murmur / Artificial heart valve			Hepatitis A / B / C		
ICD / Defibrillator / Pacemaker			TB / Tuberculosis		
Blood disorders:			HIV / AIDS		
Bruise easily			Claustrophobia		
Blood clot in legs or lungs			Smoking: Number per day:		
Shortness of breath / Persistent cough			Alcohol: Glasses per day:		
Asthma / Emphysema / CORD / COPD			Social/recreational drugs: how often:		
Obstructive Sleep Apnoea / OSA			Reduced mobility:Independent		
Diabetes: On insulin / diet / tablets			Using equipment		
Hiatus hernia / Heart burn / Stomach ulcer			Requiring assistance		
Kidney Disease / Renal Failure			Completely dependent		
Bladder problems / Bowel problems			Have you had a fall in the last 4 weeks?		
Epilepsy / Seizures / Severe headaches			Skin Conditions:		
Stroke / TIA / Blackouts			Skin ulcers / wounds / dressings		
Alzheimers / Dementia			Women – Are you or could you be pregnant?		
Mental health condition					
Neurological condition			Do you have any other implants or prostheses? (e.g. cochlear, joint)		
Are you prone to fainting ?					
Are you able to lie flat?					

Any other relevant or helpful health information you may wish to advise us of:

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ALLERGIES, REACTIONS OR SENSITIVITIES

Are you allergic to:	Yes	No	Name & reaction you have (or attach a list)
Drugs / Medicines			
Latex			
Iodine			
Plaster			
Food			

List ALL current medicines, tablets, inhalers, injections, eye drops, herbal remedies, homoeopathic, complementary medicines, vitamins and other supplements (or attach list)

Name of Medicine etc	Dose	How often

LIST ALL HOSPITAL ADMISSIONS / OPERATIONS / PROCEDURES

Hospital	Year	Reason for Admission

For patients under going GENERAL ANAESTHETIC or IV SEDATION

NB You will require adult supervision for 24 hours after your surgery.	Yes	No
What type of anaesthetic have you had in the past? General / Local (please circle)		
Have you or any family member had any problems with previous anaesthetics? If yes, please explain		
Do you suffer from motion sickness? Mild / Moderate / Severe		
Do you have problems opening your mouth? (previous jaw or neck problems/injuries) If yes, please explain		
Do you have dentures, partial plates, capped or loose teeth? (please circle)		
Is your physical activity restricted by shortness of breath/chest pain/joint pain (please circle)		
Do any of your blood relatives have any major illnesses e.g. Diabetes, Muscular Dystrophy, Malignant Hyperthermia, etc.?		
Do you have any specific questions you wish the anaesthetist to answer prior to your surgery? Please outline:		

To the best of my knowledge the above information is correct and I authorise the use of this information for purposes directly related to my healthcare.

Patient's signature: Date: / /

Person completing form if not patient:

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