Medical Questionnaire

The following questions help us to decide whether we need to see you for a pre-operative check before you are admitted to our hospital. If you need help completing the form or are unsure of the meaning of any of the questions, then please contact the hospital for advice.

Last name:
First name:
DOB:
Hospital Number:
or Patient label

Please answer the following questions and give any further details you think may be helpful to us.

Proposed operation:	**Proposed date of admission:**

Personal details

Title	Dr Mr Miss Mrs Ms	Surname	
First name		Middle name	
Date of birth		Preferred name	
Address on discharge		Phone numbers	
Town		Home	
County		Evening/Night	
Postcode		Mobile	

If we need to talk to you about your appointment/treatment, can we contact you by phone and/or leave a message if you are not available?	Yes	No

Your occupation:			
Next of kin	Name	Relationship to you?	
Address			
Telephone	Home	Mobile	
Second contact	Name	Relationship to you?	
Address			
Telephone	Home	Mobile	

Which of these people would you prefer us to contact in the first instance?					
GP name					
GP surgery					
Religion					
Do you live alone?	Yes	No	Any dependants?		
Are you worried you won't manage at home after the operation?					
Are you hard of hearing?	Yes	No	Are you visually impaired?	Yes	No
Do you have any communication problems? State:					
Is English your first language?	Yes	No	If no, will you require an interpreter?	Yes	No
Do you intend undergoing any form of continuous travel (e.g. car, train, plane) of more than 3 hours approximately 4 weeks before or after surgery?				Yes	No
Height (in cm):			Weight (in kg):		

Past Medical History

Please complete the following medical questions as accurately as possible. This is important because it enables us to be informed of any special medical needs you may have and ensures that you are safely prepared for your anaesthetic.

Last name:

First name: or Patient label

DOB:

Hospital Number:

Please tick yes or no to the following questions and give further details you think may be helpful to us.

Previous anaesthetics	Yes	No	Further details
Have you ever had problems with an anaesthetic? If 'yes' or you are not sure, please give details:			
Have any of your relatives had problems with anaesthetics? If "yes' or you are not sure, please give details.			

Allergies	Yes	No	Further details
Have you ever had a reaction to medicines or other substances (e.g. food/topical agents/latex/metal/ other)? If yes, give details of what medicine(s)/ substance(s) were involved.			

Alcohol and smoking	Yes	No	Further details
Do you drink alcohol? If yes, please give details:			Beer: ..... pints per week Spirits: ..... tots per week Wine: ..... glasses per week
Do you at present or have you ever smoked?			Cigarettes/day:..... since: ..... (year) If stopped, when: ..... (year)

Medication	
Are you currently taking any medications (prescribed, herbal, vitamins or other)? Details please (in CAPITALS):	
Name of medicine	**Name of medicine**
1	6
2	7
3	8
4	9
5	10

Heart disorders	Yes	No	Further details
Do you get chest pain or breathless climbing two flights of stairs?			
Do you suffer with angina more than once each month?			
Have you had a heart attack within the last 6 months?			
Are you currently being treated for an abnormal heart beat?			
Are you currently being treated for heart failure?			
Have you ever been told that you have a heart murmur?			
Are you being treated for high blood pressure?			
Do you have a cardiac pacemaker or internal cardiac defibrillator?			

Last name:

First name:

DOB:

Hospital Number:

or Patient label

Breathing disorders	Yes	No	Further details
Do you have asthma, emphysema, chronic bronchitis or any other breathing disorder?			
Do you have asthma attacks more than once each month?			

Brain and nerve disorders	Yes	No	Further details
Have you been diagnosed as having epilepsy?			
If yes, do you have epileptic seizures more than once a month?			
Do you suffer from fainting or blackouts?			
Have you ever had a minor or major stroke?			
Has any blood relative suffered with CJD?			
Have you ever had brain or spinal cord surgery?			
Have you ever received human pituitary hormones (growth hormone or gonadotrophin)?			
Have you been advised that you may be at risk of CJD?			

Stomach and gut disorders	Yes	No	Further details
Do you suffer regularly from indigestion or heartburn or hiatus hernia?			
Have you ever been treated for a peptic ulcer?			

Hormone disorders	Yes	No	Further details
Do you have treatment for diabetes (diabetes mellitus)?			
If yes, are you currently being treated with insulin?			
Do you have thyroid disease?			

Liver disorders	Yes	No	Further details
Have you ever had jaundice (yellowness of the skin)?			
Have you ever been diagnosed as having hepatitis?			

Bleeding disorders	Yes	No	Further details
Do you bleed or bruise very easily?			
Have you ever been diagnosed as having a blood clot in the leg (deep vein thrombosis) or in the lung (pulmonary embolus)?			
Have you, or any close relative, been diagnosed with any inherited blood disorder such as sickle cell disease?			
Have you ever been anaemic?			

Musculoskeletal disorders	Yes	No	Further details
If you sit upright in a chair, do you have difficulties putting your head back far enough to see the ceiling directly above you, while keeping your back straight?			
Have you or a family member ever been diagnosed as having an inherited muscle disease?			
Have you been diagnosed as having arthritis?			

Last name:

First name: or Patient label

DOB:

Hospital Number:

Urinary and renal disorders	Yes	No	Further details
Have you ever been diagnosed with a kidney disease?			
Are you currently treated for kidney disease?			
Have you suffered with a bladder or urine infections in the past 3 months?			

Skin disorders	Yes	No	Further details
Do you currently have any open wounds/ulcers/blisters?			

Further disorders/symptoms	Yes	No	Further details	
Have you ever been diagnosed as having any type of cancer?			**Type + treatment**	**Year**

Previous accidents, injuries, and operations	Yes	No	Further details	
Have you had a serious accident or injury? Please give details:			**Incident/injury**	**Year**
Have you previously had an operation and did you have any complications? Please give details:			**Operation + complication**	**Year**

Infection risks	Yes	No	Further details	
Have you ever suffered a serious infection (e.g. MRSA, clostridium difficile, food poisoning, diarrhoea)?			**Type + site of infection**	**Year**
Have you been treated in any hospital/care home in the past 3 months?				
Have you been in contact with anyone you know who has MRSA?				
Do you work in a hospital, nursing home or other health service environment?				

Female patients only	Yes	No	Further details
Are you or could you be pregnant? Date of last period …../…../…..			

Thank you for providing this information for us. Please sign the document to confirm that the information you have given us is correct and hand it to the Outpatient Department or return it in the envelope provided within 5 days.

Date …….. **Signature** ……