St Andrew's Anaesthetists Group LLP
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Please complete this questionnaire in as much detail as possible and return it to us at the address above. Use an additional sheet of paper if necessary. An online version is available - see over page.

Your Personal Details:					
First Name		Surname			
Date of Birth		Gender	Male/Female		
Mobile phone		Height (m)		Weight (kg)	
Your Surgeon		Your procedure			

Your Medical History:			
Have you ever suffered from any of the following?	**YES**	**NO**	**COMMENTS** please include relevant dates
Heart Attack			
Angina (chest pain on exercise, at rest or at night)			
Shortness of breath			
Palpitations			
Heart murmur			
High blood pressure			
Bronchitis or Emphysema (COPD)			
Asthma			
Stroke or Mini-stroke			
Convulsions or fits			
Kidney or urinary trouble			
Anaemia or other blood problem			
Excessive bleeding or bruising			
Indigestion, heartburn or reflux of acid into mouth			
Diabetes			
Arthritis			
Muscle or nerve disease			
Deep vein thrombosis (DVT) or blood clot in lungs			
Sickle cell disease or trait			
Any other serious disease or condition			

Your Social History:			
	YES	**NO**	**COMMENTS** add as much detail as possible
Do you undertake regular physical activity?			
Can you walk more than 200m without stopping?			
Do you smoke? *If YES, how many?*			
Do you drink more than 14 units alcohol per week?			

Your Next of Kin	
Name	
Relationship to you	
Contact Number	

Your Medications and Allergies:				
Do you take any regular medicines (tablets, inhalers, injections, patches).	**YES**		**NO**	
*If **YES**, please list all your regular medications. Including HERBAL PREPARATIONS and RECREATIONAL DRUGS. (Please use an additional sheet of paper if there is not enough space below)*				

Name of medication	Dose	How often?

Do you have any Allergies (medicines or foods)?	**YES**		**NO**	
*If **YES**, please list the medications/foods you reacted to and describe what happened.*				

Name of medication/food	Description of reaction

Your Previous Operations:				
Have you had any operations in the past?	**YES**		**NO**	
If YES, please list all your operations including date and type of anaesthetic (e.g. General, Local, Sedation)				

Name of operation	Date (approximately)	Type of Anaesthetic (if known)

Have you or your family ever had any problems with Anaesthesia?	**YES**		**NO**	
If YES, please describe what happened.				

Other Relevant Information:	YES	NO	COMMENTS
Have you had any recent infections?			
Have you been admitted to hospital in the last year?			
If female, could you be pregnant?			
Do you have any of the following? (circle any that apply)			
Dentures / Crowned teeth / Contact Lenses / Hearing Aid / Pacemaker / Internal Defibrillator / Prosthesis			
Anything else that you think we ought to know?			

It is very important that you return this questionnaire as soon as possible to STAAG at the address above. Failure to do so may result in a delay to your planned date of surgery.
DO NOT SEND THIS FORM TO THE HOSPITAL.

You can complete this questionnaire online by using the Pre-Operative Assessment link at www.staag.net
Or scan this QR code on your mobile: