HEALTH QUESTIONNAIRE

Royston DAY SURGERY
EVOLUTION HEALTHCARE

PATIENT LABEL

1. Your Weight (kg)	2. Your Height (m)	3. BMI (Body Mass Index, if you know it)	4. Do you smoke? ☐Yes ☐No If yes, how many per day:
_____	_____	_____	_____

Chest pains / tightness or angina	☐Yes ☐No	Shortness of breath	☐Yes ☐No	5. Do you drink alcohol? ☐Yes ☐No
Previous rheumatic fever	☐Yes ☐No	Asthma	☐Yes ☐No	
Previous heart attack	☐Yes ☐No	Emphysema/or COPD	☐Yes ☐No	If yes, how much and how often:
Palpitations	☐Yes ☐No	Tuberculosis	☐Yes ☐No	
Heart murmur	☐Yes ☐No	Obstructive sleep apnoea	☐Yes ☐No	_____
High blood pressure	☐Yes ☐No	Persistent cough	☐Yes ☐No	
Artificial heart valve or pacemaker	☐Yes ☐No	Stroke or seizures	☐Yes ☐No	6. Have you recently been hospitalised? ☐Yes ☐No
Hiatus hernia/heartburn/indigestion	☐Yes ☐No	Jaundice or hepatitis	☐Yes ☐No	
Diabetes – oral medication	☐Yes ☐No	Liver disease	☐Yes ☐No	If yes, where and when:
Diabetes – insulin-dependent	☐Yes ☐No	Previous DVT* or lung embolus	☐Yes ☐No	
Kidney disease	☐Yes ☐No	Bleeding or clotting disorder	☐Yes ☐No	_____
Rheumatoid arthritis	☐Yes ☐No	Thyroid disease	☐Yes ☐No	
Motion sickness	☐Yes ☐No	Epilepsy	☐Yes ☐No	

7. Have you had MRSA**? ☐Yes ☐No If yes, when?	8. Have you had ESBL***? ☐Yes ☐No If yes, when?

9. If you answered yes to any of the questions above, please give further details:

10. Please list your previous surgery, including year and hospital if known:

Surgery	Date	Hospital

11. What medications (including herbal) and/or drugs are you taking? (Include any pain relief medication)

Drug	Dose	Time Taken

12. Do you have any allergies or adverse reactions to medications, food, latex or any other Substance? ☐Yes ☐No

Drug	Type of Reaction

*DVT = Deep Vein Thrombosis
**MRSA = Methicillin-resistant Staphylococcus aureus
***ESBL = Extended spectrum beta-lactamase

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

☐Yes ☐No If 'Yes', please list. E.g. diabetes, muscular dystrophy, malignant hyperthermia

14. Have you or any of your family had problems with an anaesthetic?

☐Yes ☐No If 'Yes' please outline

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

16. Have you been told of any difficulties during your anaesthetic? ☐Yes ☐No

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

18. What physical activities do you take part in on a regular basis? (Tick those that apply)

☐ Walking ☐ Gym Work ☐ Tennis ☐ Golf ☐ Other (specify)

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

☐ One flight ☐ Two flights ☐ Three flights or more

20. My activity is restricted by: ☐ Shortness of breath ☐Chest pain ☐Joint pain

21. Do you suffer from any other condition, not covered elsewhere, that you feel we should know about?

☐Yes ☐No If 'Yes' please outline

22. Do you have any concerns or questions about your anaesthetic?

☐Yes ☐No If 'Yes' please outline

23. Women only – are you or could you be pregnant? ☐Yes ☐No

Signatures

I give permission for my/my child's medical records and investigation results to be accessed for the purpose assisting in my anaesthetic ☐Yes ☐No

The above details have been completed by ☐Patient ☐Guardian ☐Relative ☐Other

Specify: _____

Signature: _____ Date: _____ Print Name: _____

If your anaesthetist believes there are significant risks identified in this questionnaire, he/she may contact you to make an appointment before surgery.

Please bring all your medications with you to hospital.