

## ASSESSMENT FOR SURGERY

### PATIENT QUESTIONNAIRE

AFFIX ADDRESSOGRAPH LABEL

NAME: \_\_\_\_\_

HOSPITAL NO: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

**Will you:-**

PLEASE TICK THE CORRECT BOX

be able to be driven home by private car?..	YES	NO
have someone to take you home?..	YES	NO
have a telephone at home?..	YES	NO
have easy access to a lavatory?..	YES	NO
have someone at home to look after you for 24 hours?..	YES	NO

DATE COMPLETED

/ /

**Have you ever suffered from any of the following?:-**

heart attack...	YES	NO	—• If so, when? _____
angina (chest pain on exercise, at rest or at night)...	YES	NO	
breathlessness (shortness of breath)...	YES	NO	—• If yes, answer the following:
asthma...	YES	NO	a. do you feel breathless:
bronchitis...	YES	NO	at rest
high blood pressure...	YES	NO	on lying flat
heart murmur...	YES	NO	on exertion
rheumatic fever...	YES	NO	on climbing stairs
convulsions or fits...	YES	NO	
kidney or urinary trouble...	YES	NO	b. how far can you walk
anaemia or other blood problem...	YES	NO	before breathlessness
excessive bleeding or bruising...	YES	NO	stops you
hepatitis...	YES	NO	<input style="width: 50px; height: 20px;" type="text"/> yards
severe indigestion or heartburn...	YES	NO	
diabetes...	YES	NO	—• If yes, is it:
arthritis...	YES	NO	diet controlled <input style="width: 30px; height: 20px;" type="text"/>
muscle disease (e.g., muscular dystrophy) or weakness...	YES	NO	tablet controlled <input style="width: 30px; height: 20px;" type="text"/>
deep vein thrombosis or blood clot in lungs (PE)...	YES	NO	insulin controlled <input style="width: 30px; height: 20px;" type="text"/>
swollen ankles...	YES	NO	
Do you have a pacemaker?...	YES	NO	
Do you have sickle cell disease or trait?...	YES	NO	<input style="width: 30px; height: 20px;" type="text"/>

**What is your Height?** .....

**Blood pressure** .....  
(To be completed by nurse)

**What is your Weight?** .....

**Heart rate** .....  
(To be completed by nurse)

**Have you ever had** a serious illness (if yes please name it).....

ALLERGY or reaction to medicines, elastoplast, latex, etc.....

**If a woman**, are you pregnant or taking the “pill” or HRT?.....  
(PLEASE NOTE THAT YOU MAY NEED TO BE OFF THE PILL FOR AT LEAST **FOUR WEEKS** BEFORE SOME OPERATIONS)

**Do you have** any of the following (please circle).....

Dentures	Crowned teeth	Contact lenses
Hearing aid	Pacemaker	

*Please turn over...*

**Do you:**

take any regular medicines (tablets, patches, injections, inhalers)?... 

YES	NO
-----	----

 ...If yes please list 1.....  
2.....

smoke (cigarettes/pipe)?.. 

YES	NO
-----	----

 3.....  
4.....  
5.....

drink more than 1 1/2 pints of beer or 3 shorts a day?... 

YES	NO
-----	----

use any drugs recreationally?... 

YES	NO
-----	----

 ...If yes please list .....

**TYPE OF ANAESTHETIC USED**

What **operations** have you had before if any? 1..... GA / SPINAL / LOCAL  
(please list) 2..... GA / SPINAL / LOCAL  
3..... GA / SPINAL / LOCAL  
4..... GA / SPINAL / LOCAL  
5..... GA / SPINAL / LOCAL

Did you have any **anaesthetic or surgical complications?** (please list) 1.....  
2.....  
3.....

Is there **anything else** the surgeon/anaesthetist should know?  
.....

Have you any **questions** about the procedure?.....  
.....  
.....

Has **any member of your family** had problems with anaesthetics?.....  
If so, what, when, who?.....

Should you have any difficulty in answering any of the above questions **please consult your family Doctor.**

**Thank you for completing this questionnaire.**

<b>TO BE COMPLETED BY SURGEON</b>	
REMARKS:	PRIORITY: ROUTINE / SOON / URGENT
PROPOSED OPERATION:	DAY CASE / INPATIENT
CHECK LIST:	LA / GA
CONSENT	
PREMED                      TTOS	
INVESTIGATIONS COMPLETED	
FBC U/E CXR PFT ECG OTHERS	
DATE FOR OPERATION: ...../...../.....	WARD.....