Health Questionnaire

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.

Please complete the questionnaire fully (giving any further details you feel may be helpful).

Consultants name
Procedure / treatment interest

PERSONAL DETAILS	
Title	First name
Middle name(s)	Surname
DOB	Preferred name
Address	Home phone no
	Evening phone no
Town	Mobile phone no
County	Email address
Postcode	

FURTHER INFORMATION	YES	NO	FURTHER DETAILS
If we need to talk to you about your appointment, can we contact you by phone and/or leave a message if you are not available?	☐	☐	
Have you had previous treatment at this clinic before? *If 'yes', please give details*	☐	☐	
Your occupation			
Next of kin name		Relationship to you	
Home phone no		Mobile phone no	
Do you live alone?	☐	☐	
Are you hard of hearing?	☐	☐	
Are you visually impaired?	☐	☐	
Do you have any communication problems, or special learning needs? *If 'yes', please give details*	☐	☐	
Do you have someone to look after you at home after your treatment?	☐	☐	

GP DETAILS
GP name
GP surgery

Height	Weight

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Health Questionnaire

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 a previous anaesthetic? *If 'yes', or you are not sure, please give details.*	☐	☐	

ALLERGIES	YES	NO	FURTHER DETAILS
Have you ever had a reaction to medicine or other substances (e.g. food/topical agents/latex/metal/other)? *If 'yes', give details of what medicine(s)/substance(s) were involved.*	☐	☐	

ALCOHOL, SMOKING & EXERCISE	YES	NO	FURTHER DETAILS
Do you drink alcohol? *If 'yes', please give details.*	☐	☐	Beer ..... pints per week Spirits ..... measures per week Wine ..... glasses per week
Do you currently, or have you ever smoked?	☐	☐	Cigarettes/day ..... since ..... (year) If stopped, when? ..... (year)
Do you undertake regular exercise?	☐	☐	Type ..... How often? ..... times a week

MEDICATION (Are you currently taking any medications (prescribed, herbal, vitamins or other)? If 'yes', please give details)	
Name of medicine	Name of medicine
1.	4.
2.	5.
3.	6.

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 heart failure?	☐	☐	
Have you ever been told that you have a heart murmour?	☐	☐	
Are you being treated for high blood pressure?	☐	☐	
Do you have a cardiac pacemaker or internal cardiac defibrillator?	☐	☐	
Do you or have you had any palpitations or an irregular heart beat?	☐	☐	

Health Questionnaire

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?	☐	☐	
Have you ever had brain or spinal cord surgery?	☐	☐	

HORMONE DISORDERS	YES	NO	FURTHER DETAILS
Do you have treatment for diabetes (diabetes mellitus)?	☐	☐	
If 'yes', are you currently being treated with insulin?	☐	☐	

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?	☐	☐	

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
Do you have or have you ever had any thyroid problems, either over active or under active? *If 'yes', please give details*	☐	☐		

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Health Questionnaire

Bella Vou Pantiles Clinic

FURTHER DISORDERS/SYMPTOMS	YES	NO	FURTHER DETAILS	
Have you previously had an operation?	☐	☐	Operation	Year
If 'yes', were there any complications?			Complications	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 a patient for more than 24 hours in any hospital, or a resident in a care home in the last 6 months, or had frequent contact with any health care services?	☐	☐		
Do you work in a hospital, nursing home or other health service environment?	☐	☐		
Have you ever been colonised with MRSA or advised you are/ have been a carrier of MRSA?	☐	☐		
Have you had any recent coughs, colds or viruses? *If 'yes', please describe*	☐	☐		

FEMALE PATIENTS ONLY	YES	NO	FURTHER DETAILS
Are you, or could you be pregnant?	☐	☐	Date of last period

OTHER MEDICAL CONDITIONS	YES	NO	FURTHER DETAILS
Is there any other medical condition or problem, not previously mentioned, that you feel we should know about?	☐	☐	

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 back to a nurse or receptionist (or if it has been sent to you in the post, please return it to us within 48 hours).

PRINT NAME	Signature	Date
Clinician Name	Signature	Reviewed?
OFFICE NOTES		

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