Pre-admission Health Questionnaire

Local Anaesthetic/Endoscopy/Block and Sedation procedures

Issue **January 2023** Review **January 2026**

NEW VICTORIA HOSPITAL

Please complete this form and return it no later than 5 days before admission to **dayunit@newvictoria.co.uk**

Failure to do so may lead to the procedure being cancelled or postponed

Thank you

The information you provide is essential in helping to evaluate your medical health before your operation/procedure to ensure that you get the right care.

Any questions on medication (e.g.. anti-coagulant and diabetic medications) and preparation please contact your consultant.

Name _____ **Date of Birth** ____ ____ _____

Telephone number _____ **Age** _____

Proposed Operation/Procedure _____

Hospital Consultant _____ **Hospital Admission Date** ____ ____ _____

Height _____ **Weight** _____

Allergies

Do you have any drug or food allergies or sensitivities? YES ☐ **NO** ☐ If YES, please give details of drug/food with main symptoms experienced (e.g. anaphylaxis, general or localised rash, wheezing, vomiting, and abdominal bloating) below:

Allergies

Medication

Do you take any medication? YES ☐ **NO** ☐ If YES, please list medications with dose and frequency taken below (please also include over the counter medication, such as Ibuprofen, Aspirin, etc.):

Medication

Please can you state below if you take steroid medication (tablets, inhalers, creams)

Name of drug: _____

Dose: _____ **Do you carry an Emergency Steroid Card? YES** ☐ **NO** ☐

Do you take any complimentary medicine or supplements? YES ☐ **NO** ☐ IF YES, please give details. This includes herbal supplements, vitamins and homeopathic preparations:

Please stop taking homeopathic, vitamin or herbal supplements at least 7 days prior to surgery as some preparations can affect blood clotting and cause bleeding during surgery.

Please now complete the medical history and information questions on the following two pages

Medical history and information

Do you currently have or have you ever been diagnosed with any of the following conditions? Please answer YES/NO accordingly and if YES, please give detail of condition with date if possible

		YES	NO	Please specify condition and date
1.	**Heart rhythm problems or heart related abnormalities?** (e.g. Irregular heartbeat (arrhythmia), heart murmur			
2.	**Angina or any cardiac/heart related chest pain?**			
3.	**A heart attack** (i.e. coronary thrombosis/myocardial infarct)**?**			
4.	**High or low blood pressure?**			
5.	**Have you had a cardiac pacemaker fitted or implantable cardiac defibrillator?**			
6.	**Do you faint easily?** IF YES: When and why does this happen?			
7.	**A Stroke (CVA) or Transient Ischemic Attack (TIA)?** If YES, please specify			
8.	**Epilepsy (Seizures)?**			
9.	**Respiratory disease/ breathing or airway problems** (e.g. Asthma, COPD, sleep apnoea or any other condition)**?**			
10.	**Unexplained or sudden shortness of breath?**			
11.	**Have you had a recent chest infection** (within 12 weeks)**?** Were you treated with antibiotics?			
12.	**Acid reflux ("heart burn")/indigestion/hiatus hernia?** Please specify			
13.	**Bowel problems** (e.g. Constipation, Irritable Bowel Syndrome, Inflammatory bowel disorder)**?**			
14.	**Jaundice or liver/hepatic disease?**			
15.	**Kidney/renal disease or failure?**			
16.	**Have you had a Urinary Tract Infection within the last 3 months?**			
17.	**Have you taken antibiotics within the last 3 months?**			
18.	**Any blood disorder?** (e.g. Anaemia, Sickle cell, Blood clotting/bleeding, Excessive bruising) Please give details of any blood disorder			

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		YES	NO	Please specify condition and date
19.	**Blood clot in the leg – Deep Vein Thrombosis (DVT)?**			
20.	**Blood clot in the lungs – Pulmonary Embolism (PE)?**			
21.	**Diabetes?** If YES, please specify Type 1 or 2 and how is it controlled? Diet / Tablet / Insulin			
22.	**Over active or underactive Thyroid gland?**			
23.	**Received hormones derived from human pituitary glands**, e.g. human growth hormone, gonadotrophin?			
24.	**Inflammatory diseases, such as Rheumatoid Arthritis or Polymyalgia Rheumatica?**			
25.	**Muscular disease, weakness or muscular dystrophy?**			
26.	**Physical damage or arthritis in the neck or back** IF YES: How does this affect you?			
27.	**Any physical disability** ?			
28.	**Depression or any mental health related illness?**			
29.	**Dementia/Alzheimer's disease?**			
30.	**Any other medical condition?**			
31.	**Have you had previous surgery?** If YES, please specify type and year if known.			
32.	**Do you have any implants / metalwork e.g. screws, plates, pins, stents, breast / dental implants?**			
33.	**Have you had any surgery involving graft of human tissue, such as skin graft, bone graft, corneal transplant?**			
34.	**Have you ever been notified that you are at an increased risk of CJD or vCJD?**			
35.	**Have you had any problems with a general anaesthetic?** If YES, please specify symptoms			
36.	**Have you had any serious infectious or tropical diseases?**			
37.	**Have you been admitted to hospital in the last 6 months for 24 hours or more?**			
38.	**Do you work in a healthcare setting?**			
39.	**Do you reside in a nursing/residential home?**			

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		YES	NO	Please specify condition and date
40.	**Have you ever been diagnosed with MRSA or been in close contact with someone who has MRSA?** (hospital super bug)?			
41.	**Do you smoke?** If YES, how many cigarettes per day?			
42.	**Do you drink alcohol?** If YES, how many units do you drink per week? (1 x pint beer=3 units, 1 x25ml spirit= 1 unit, 1 x Sm/Med/Lge glass of wine= 1.5/ 2/ 3 units respectively)			

For female patients only

		YES	NO	Please specify condition and date
43.	**Could you be pregnant?**			
44.	**Are you taking Hormone Replacement Therapy (HRT)?** If YES, please specify:			
45.	**Do you take contraceptive medication?** If YES please specify the type e.g. Depo-Provera, implant, Mirena			
46.	**Are you breast feeding?**			

Patient/Client sign and print name please: _____

Hospital use only

Form checked/sign and print name please: _____

Action taken: