Salisbury
NHS Foundation Trust

Patient Label

Health Screening Questionnaire

We would be very grateful if you could complete the following questionnaire on your general health. Your answers will help us identify any potential problems before you are admitted so that you can be safely prepared for your operation. Please ask a member of staff if you have difficulty in answering any of the questions.

Patient name: Hospital number:	Planned operation: **To be completed by theatre booking staff:**
Consultants name:	Planned date of admission:

Personal Details / label	*Next of Kin*
Title : Dr Mr Mrs Ms Miss First Name: Surname: Preferred name: Date of birth: Age Address on discharge: Home Tel. No: Work No: Mobile No:	Name: Relationship: Address: Home Tel. No: Mobile No:
GP name: GP surgery:	2nd Contact Name: Relationship to you?: Tel. No:

Are we able to contact you by phone and/or leave a message if you are not available?	Yes	No
Do you live alone?	Yes	No
Please give us your email address if you are happy for us to contact you by email:		
Who will be looking after you for the first 24h when you go home?		
Remember to make arrangements if you think that you will require extra help at home after this procedure		
Important: your weight = **your height =**		

Please tick Yes or No to the following questions and give further details you think may be helpful to us.

1. Heart Disease	*Yes*	*No*	*Further details*
Do you get chest pain or become breathless climbing two fights of stairs?			
Do you suffer with angina?			
Have you had a heart attack? If 'yes' please give year.			
Are you currently being treated for an irregular heart beat?			
Have you ever been treated for heart failure?			
Have you ever been told you have a heart murmur?			
Are you being treated for high blood pressure?			
Do you have a pacemaker or implanted defibrillator?			If yes, In which hospital was it inserted? Date of last check:
Do you have any coronary stents?			If yes, how many: Date of insertion:
Do you have or have you had an aortic aneurysm?			
Were you born with a congential heart defect?			
Do you have mitral valve disease?			

Hospital treatment	*Yes*	*No*	*Further details*
Have you been hospitalised or received any medical treatment in a hospital abroad in the last 12 months, or been an inpatient in London or Manchester in the last 12 months?			

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?			

Female patients only	*Yes*	*No*	*Further details*
Are you or could you be pregnant? Date of last period			
Are you taking a combined oral contraceptive pill or Hormone Replacement Therapy?			

Do you have any questions you would like to discuss with a pre-assessment nurse or any specific requirements related to your care?

Thank you for providing this information for us. Please sign the document to confirm
1. that the information you have given us is correct.
2. that you are happy for us to access your health record from your GP's computer system.

If you are filling this in at home please return it to: The Theatre Booking Department, Salisbury District Hospital, Salisbury, Wilts, SP2 8BJ within 10 days.

Date... Signature...

For nursing or medication advice, please call the Pre-Operative Assessment Unit on 01722 336262 ext 4551. Or email: sft.poau@nhs.net
For dates or appointment advice, please call the Central booking office on 01722345543. Or email: Centralbooking.salisbury@nhs.net

Please do not complete this section. For hospital use only

Baseline Observations / Health Screen			
BMI			
Pulse rate	Pulse regular [ ] Pulse irregular [ ]*	Can the patient transfer independently	Yes [ ] No [ ]*
Blood pressure	>180/110*	Patient needs further assessment	Yes [ ]* No [ ]
Respiratory rate		Mental Test Score	Yes [ ]* No [ ]
O2 Sats		If positive, send standard letter to GP	Yes [ ]
		* refer to POAU Nurse	
Screening Nurse			

Have you discussed the benefits of stopping smoking?	Yes	No
(Explain nicotine containing products can be provided whilst a smoke-free inpatient) - Offered NRT?	Yes	No
Would you like support to give up?	Yes	No
Inpatient referal to Smoking Cessation Nurse? (Tel 07717 808259)	Yes	Declined
Referral to GP?	Yes	

Final Score
A total of 5+ indicates increasing or higher risk drinking. **An overall score of 5 or above is AUDIT-C Positive**

Was brief advice given?	Yes	No
Reffered to Alcohol Liason Nurse (Bleep 1022 / ex 2574) ?	Yes	Declined

Signature: Name (print): Date: Band:

❑ FBC ❑ normal ❑ after iron ❑ U+E's ❑ normal ❑ HbA1C ❑ <69mmol/mol ❑ ECG
❑ Patient will call in with list of medicines ❑ MSU ❑ Normal MRSA Swabs taken Yes ❑ No ❑
❑ TFT ❑ OFT

Signature: Name (print) Date: Band:

*For hospital use only

2. Breathing Disorders	Yes	No	Further Details
Do you have asthma, emphysema, chronic bronchitis, COPD, bronchiectasis or any other breathing disorder?			Please indicate which, If yes.
Do you have Sleep Apnoea?			If yes, do you use CPAP?
Do you currently smoke Tobacco?			
Are you an ex-smoker?			
If an ex-smoker, how long did you smoke for?			
How many cigarettes do you smoke per day?			

3. Hormone, renal, liver & bleeding disorders	Yes	No	Further Details
Do you have diabetes (diabetes mellitis)?			If yes, most recent Hba1c - Date:
If 'yes' are you treated with insulin or tablets?			
Do you have thyroid disease?			
Have you ever been diagnosed with a kidney disease?			
Have you ever been diagnosed as having hepatitis?			
Do you bleed very easily?			
Have you ever been diagnosed as having a blood clot in the leg (deep vein thrombosis) or in the lung (pulmonary embolism)			If yes, how long ago?
Have you, or any close relative, been diagnosed with any inherited blood disorder such as sickle cell disease, clotting or bleeding disorder?			
Do you currently drink alcohol?			

Questions	0	1	2	3	4	Score
How often do you have a drink containing alcohol?	Never	Monthly or Less	2-4 Times per Month	2-3 Times per Week	4 Times per Week	
How many units of alcohol do you drink on a typical day?	1-2	3-4	5-6	7-9	10+	
How often have you had **6 or more units (if female)** or **8 or more (if male)** on a single occasion in the last year?	Never	Less than Monthly	Monthly	Weekly	Daily or Almost Daily	

4. Stomach & gut disorders	Yes	No	Further Details
Do you have difficulty swallowing?			
Do you suffer regularly from acid reflux coming up into your mouth?			
Do you have you a stomach ulcer?			

5. Brain, nerve & musculoskeletal disorders	Yes	No	Further details
Are you registered blind?			
Do you have severe hearing loss?			
Have you been diagnosed as having epilepsy?			If yes, date of last seizure
Do you suffer from fainting or blackouts?			
Have you ever had a minor (TIA) or major stroke?			If yes, how long ago?
Do you suffer with anxiety or depression?			If yes, please specify
Do you have learning disabilities?			
Do you have dementia?			
Have you ever been told that you are at risk of CJD or vCJD for public health purposes?			
Please answer the following question **only** if you are having eye surgery.			
Has anyone in your family ever had CJD (or other similar prion disease)?			If 'yes' please give details:
Have you received Growth Hormone or gonadotrophin treatment?			

If 'yes' please indicate what the hormone was: human origin ❑ I do not know ❑

What year did you receive treatment? __________ In what country did you receive treatment? __________

5. Brain, nerve & musculoskeletal disorders	Yes	No	Further details
Do you have a spinal cord injury which has resulted in paraplegia or tetraplegia?			If 'yes' at what level of the spine was the injury? Do you have any respiratory support? Do you suffer from dysreflexia?
If you sit upright in a chair, do you have difficulties putting your head back far enough to see the ceiling directly above you, while keeping your back straight?			
Have you or a family member ever been diagnosed as having an inherited muscle disease?			
Have you been diagnosed as having arthritis?			If yes, which type?
Do you use a mobility aid (e.g. sticks, walking frame or wheelchair)?			
Are you able to lie flat comfortably?			

6. Anaesthetics & previous operation	Yes	No	Further details
Please give details of any previous operations? Operation / Year			Operation / Year
Have you ever had problems with a previous anaesthetic?			If 'yes' please give details.
Have any of your relatives had problems with anaesthetics?			If 'yes' please give details.

7. Skin & further disorders	Yes	No	Further details
Do you currently have any open wounds / ulcers / blisters?			
Have you ever been diagnosed as having any type of cancer?			Please give details:

Medication

Are you currently taking any medications (prescribed, herbal, over the counter, recreational, vitamins or other)?

Please give details (in CAPITALS) or attach GP list

Name of medicine	dose	freq.	Name of medicine	dose	freq.
1			9		
2			10		
3			11		
4			12		
5			13		
6			14		
7			15		
8			16		

Please indicate if you are taking any of the following?	Yes	No	Further details
Anticoagulant tablets (such as warfarin, aspirin or clopidogrel, prasugrel, dabigatran, apixaban) Rivaroxaban, Dipyridamole, Ticagrelor			
MAOI tablets (you will carry a card if you do)			

Allergies	Yes	No	Further details
Have you ever had a reaction to medicines or other substances (e.g. food/topical agents/latex/metal/ other)? If 'yes' please give details.			

Infection risks	Yes	No	Further details
Have you ever suffered a serious infection (e.g. MRSA, clostridium difficile? If 'yes' please give details			