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			

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.
Please bring the completed form with you when you attend for your appointment.

Date..... Signature.....

If you have any queries, please telephone the Radiology Booking Team on 01722 336262 ext. 4282

Please do not complete this section. For hospital use only

Baseline Observations / Health Screen			
Temperature		BMI	
Pulse rate	Pulse regular [ ] Pulse irregular [ ]*	MRSA Swabs taken	Yes [ ] No [ ]
Blood pressure	>170/100*	Can the patient transfer independently	Yes [ ] No [ ]*
Respiratory rate		Patient needs further assessment	Yes [ ]* No [ ]
O2 Sats		Mental Test Score If positive, send standard letter to GP	Yes [ ]* No [ ] Yes [ ]
Screening Nurse		* refer to POAU Nurse	
Signature:	Name (print):	Date:	Band:

❑ FBC ❑ normal ❑ U+E's ❑ normal ❑ HbA1C ❑ <69mmol/mol ❑ ECG
❑ Patient will call in with list of medicines
Signature: Name (print) Date: Band:

Salisbury NHS
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:
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: 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
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 flights 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?			
Do you have any coronary stents?			

2. 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?			
Do you have Sleep Apnoea?			
Do you smoke now?			
If 'yes' would you like to give up?			
If 'yes' would you like to be referred to the 'NHS Stop Smoking Service'			

3. Hormone, renal, liver & bleeding disorders	Yes	No	Further Details
Do you have diabetes (diabetes mellitis)?			
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 drink more than 1½ pints of beer or 3 shorts or ½ bottle of wine per day most days?			
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 embolism)			
Have you, or any close relative, been diagnosed with any inherited blood disorder such as sickle cell disease, clotting or bleeding disorder?			

4. Stomach & gut disorders	Yes	No	Further Details
Do you suffer regularly from indigestion or heartburn or hiatus hernia?			

5. Brain, nerve & musculoskeletal disorders	Yes	No	Further details
Have you been diagnosed as having epilepsy?			
Do you suffer from fainting or blackouts?			
Have you ever had a minor (TIA) or major stroke?			
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?
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?
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?			

5. Brain, nerve & musculoskeletal disorders	Yes	No	Further details
Have you or a family member ever been diagnosed as having an inherited muscle disease?			
Have you been diagnosed as having arthritis?			
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)			
MAOI tablets (you will carry a card if you do)			