**Health Screening Questionnaire**

**Please complete this questionnaire and email it to:** [**sft.poau.patients@nhs.net**](mailto:sft.poau.patients@nhs.net)

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | | |
| Date of Birth |  | | |
| Telephone Number |  | | |
| Email Address |  | | |
| NHS or Hospital Number  (on the letter you received) |  | | |
| Who will be looking after you for the first 24 hours when you go home? |  | | |
|  |  |  |  |
| **Please tick yes or no to the following questions and give further details you think may be helpful** | **Yes** | **No** | **Details** |
| Do you need an interpreter, if so what language? |  |  |  |
| Do you need wheelchair access? |  |  |  |
| Do you have a spinal cord injury which has resulted in paraplegia or tetraplegia?  If yes? |  |  | If yes, at what level of  the spine was the injury? |
| Do you have any respiratory support? |  |  |  |
| Do you suffer from dysreflexia? |  |  |  |
| Are you registered blind? |  |  |  |
| Do you have severe hearing loss? |  |  |  |
| Do you have learning or any other disabilities? |  |  |  |
| Do you have dementia? |  |  |  |
|  |  |  |  |
| Do you have coronary stents? |  |  | If yes, how many:  Date of insertion: |
| Do you have a pacemaker or implanted defibrillator? |  |  |  |
| Have you ever had a TIA or a Stroke? |  |  | If yes, how long ago: |
| **Please tick yes or no to the following questions and give further details you think may be helpful** | **Yes** | **No** | **Details** |
| Are you taking any regular medications? |  |  | If you tick yes, we will check them on your GP record |
| Are you taking any blood thinning tablets (such as warfarin, aspirin, clopidogrel, prasugrel, dabigatran, apixaban, edoxaban, rivaroxaban, dipyridamole or ticagrelor)? |  |  |  |
| Are you taking any herbal remedies? |  |  |  |
| Do you have diabetes? |  |  | If yes, are you treated with:  Insulin  Tablets |
| Do you have sleep apnoea?  (if yes, please bring your CPAP machine with you into hospital) |  |  |  |
| Have you ever been told you have MRSA? |  |  |  |
| Have you been in hospital for longer than a week in the last 6 months? |  |  |  |
| Do you have a urinary catheter? |  |  |  |
| Have you ever had problems with a previous anaesthetic? |  |  |  |
| Have any of your relatives had problems with anaesthetics? |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| How far can you walk on  the flat without stopping? (eg. 400 metres) |  | What stops you walking further?  (eg. Joint/limb pain, shortness of breath, chest pain) |  |  |
| Estimated height |  |
| Estimated weight |  |

If you need help with this questionnaire, please ask a friend or relative to help you.

If you need to contact the Pre-Operative Assessment Unit nurses, call 01722 336262 ext 2587.

If no one can get to the phone because we are busy, please leave a message with your name, hospital number and telephone number and we will call you back.