

## MEDICAL -- TREATMENT -- OVERSEAS.CO.UK

### Pre-operative Questionnaire

The information you provide will greatly assist hospital staff in preparing and caring for you throughout your stay in Hospital. If there is something significant not included in the questions please add it at the end of the second page.

Please answer the questions, yes or no and add any additional information under comments.

- |  | YES | NO | Comments |
|--|-----|----|----------|
| 1. Do you suffer from any allergies?   |     |    |          |
| 2. Do you take any medication regularly?<br>If so please list any tablets, syrups, lotions, creams, inhalers or patches that you take regularly. |     |    |          |
| 3. Do you have asthma?   |     |    |          |
| 4. If so, when was your last attack?   |     |    |          |
| 5. Are you a diabetic?<br>If so, do you control your sugar level by:-<br>diet<br>insulin injection<br>tablet                                     |     |    |          |
| 6. Are you epileptic?<br>If so, when was your last fit?  |     |    |          |
| 7. Do you suffer from bronchitis or any breathing difficulty?  |     |    |          |
| 8. Do you suffer from high blood pressure?   |     |    |          |
| 9. Have you experienced heart problems?  |     |    |          |
| 10. Do you get breathless or have chest pain on exercise?  |     |    |          |
| 11. Do you get breathless or have chest pain at night?   |     |    |          |
| 12. Do you ever have swollen ankles?   |     |    |          |
| 13. Have you had any rheumatic fever?  |     |    |          |
| 14. Do you have arthritis?   |     |    |          |

15. Do you have any difficulty moving around?

16. Have you ever had kidney disease?

17. Have you ever had liver disease or been jaundiced?

18. Do you suffer from anaemia or any blood disorder?

19. Do you tend to bruise or bleed easily?

20. Do you have a cough, cold or sore throat?

21. Will this be your first operation?  
If not please list previous operations.

22. Have you had a general anaesthetic in the past?

23. Have you experienced any problems with anaesthetics?  
If so please describe the problem, briefly.

24. Have any of your family had problems with anaesthetics?

25. Do you smoke? Please indicate the number per day.

26. Do you drink alcohol? How much per week?

27. Do you have any dental crowns or wear false teeth?

28. What is your weight?

29 What is your height?

30 What is your date of birth?

Patients signature.....DATE.....