Patient Name: _____ DOB: ____ / ____/ _____

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The Andrology Clinic

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Visit us at www.theandrologyclinic.com

Pre-Operative Assessment Form

Booking Company: _____

Surgeon: _____

Procedure: _____

Dear Patient,

As you have now decided to proceed with your chosen surgical procedure, we would like to further investigate your general wellbeing, and to perform some standard tests to ascertain your physical status for surgery. Please take the time to complete this questionnaire carefully and inform the Doctor of any issues that may affect your suitability for surgery.

This information is confidential and will only be used to maximise your care and safety whilst in the hospital.

Personal Details		
Title:	Full Name:	
Address:		
Postcode:	Country:	Date of Birth: ___ /___ /_____
Mobile telephone:		Age:
Home telephone number:		Occupation:
Email address:		

GP Details	
GP Name:	GP Telephone number:
GP Address:	
Postcode:	Country:
NHS Number:	

Emergency contact	
Title:	Full Name:
Telephone number:	Relationship:
Address (including postcode):	

Please note the following:

- All patients must stop smoking at least 2 weeks preoperatively and preferably 4 weeks.
- Aspirin, Vitamin C and E and all fish oils and Omega 3 & 6 supplements to be stopped 2 weeks preoperatively.
- All drugs to be continued until the morning of operation except for certain antihypertensive drugs to be decided at the preoperative consultation (today), e.g. ACE inhibitors should be stopped 1 day preoperatively.
- Fasting: All patients to stop solid food 6 hours preoperatively Water may be taken up to 3 hours preoperatively.
- You should not drink alcohol, drive, or operate machinery for 48 hours after your anaesthetic.
- You should have someone take you home by car.
- You should have someone to look after you overnight.

Please ANSWER the following questions (circle as appropriate):

- Is your general health good? YES / NO
- Are you currently pregnant? YES / NO
- Do you smoke? YES / NO
- Do you have any allergies (Food, medication, latex)? YES / NO
  If yes, please specify:
- Do you have any medical problems? YES / NO
  If yes, please specify:
- Have you had any recent infection? YES / NO
  If yes, please specify:
- Have you used any antibiotics in the last 4 weeks? YES / NO
  If yes, when and for what reason?
- Have you had any history of a previous blood clot in the legs or lungs (DVT/PE)? YES / NO
  If yes, please provide details:

Please provide details of your current medications (incl. HRT, Contraceptives)

Is there any information your surgeon or anaesthetist should know before your surgery? YES / NO
If yes, please specify:

I certify that the information given on this form is correct:

Patient Name: _____

Patient Signature: _____

Date: _____ / _____ / _____