Enter a New World
of Medical Excellence

The Andrology Clinic

Tel (0)20 7034 3301 Fax: (0)20 7034 3362

PRE-OPERATIVE PATIENT QUESTIONNAIRE

Patient Details

Name: ______________________________ Date of Birth: ______________

Address: ____

____

Post Code: ____________________ Admission Date: ____________________

Tel No: ____________________ Occupation: ____________________

Weight in Kg: __________ BP: ______________ Pulse: ______________

Proposed Operation: ____

Surgeon / Doctor: ____

Please answer all of the following questions by putting a tick in the boxes	Yes	No
Do you have a responsible adult to take you home and look after you after the operation/procedure for 24 hours?		
Is your traveling time from hospital less than one hour?		
Will you have access to a telephone at home?		
Heart Disease/Rheumatic Fever		
Palpitations		
High Blood Pressure? BP =		
Chest Pains		
Swelling of Ankles		
Shortness of Breath? with exercise [ ] at rest [ ]		
Arthritis or Muscle Disease		
Asthma/Bronchitis		
Chronic Cough		
Diabetes		
Epilepsy		
Jaundice?		
Urinary or Kidney Problems Urine Test =		
Indigestion or Heartburn		
Excessive Bleeding/Bruising		
Anaemia		
Are you taking any Medicines? (Pills, Inhalers, Injections, Patches) Please list:		

Have you any allergies? Please list:		

	Yes	No
If Female - Are you pregnant (or could be) or taking the oral contraceptive pill (“the pill”)?		
Do you smoke? How many per day?		
Do you drink alcohol? How many units per week?		
Have you or anyone in your family ever had a problem with anaesthetics in the past? Give details:		
What operations have you had in the past (if any)? Give details:		
Is there anything about yourself or your family’s medical history you think we should know about? Have you or your family had recent contact with MRSA?		
Do you have any of the following Dentures, Crowned Teeth, Contact Lenses, Hearing Aid, Pacemaker?		
Is there anything you would like to discuss concerning your procedure at the Queen Anne Street Medical Centre? - Medication - Pain Control If so please give details		

Please return this completed form to the theatre staff at the Queen Anne Street Medical Centre, thank you.

For Official Use

Comments:
Signed: