# Image result for gstt logo**Health Questionnaire**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Date of Birth |  |
| Contact number |  | | |
| GP and Surgery name |  | | |
| If you have moved to a new address, please update it by speaking to the receptionist. Thank you. | | | |

**Next of Kin detail:**

|  |  |
| --- | --- |
| Name |  |
| Relationship to you |  |
| Contact number |  |

**Allergies**

|  |  |
| --- | --- |
| List all Known | Please detail reaction |
|  |  |

**Native language**………….………..…..…. Do you need an interpreter for your appointment? No Yes

(Use of family members or friends as interpreters is not allowed)

**Social**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Live alone |  | With Family |  | With Partner/ Spouse |  | With Friends |  | Shared accommodation |  |
|  |  | Do you have any children? Y / N If yes, of what age? | | | | | | | |

If you are going to have a procedure with sedation or under general anaesthesia, have you arranged an escort home and someone to stay at home with you for the next 12 hours? Please write the escort details below.

**Escort Details**

|  |  |
| --- | --- |
| Name |  |
| Relationship to you |  |
| Contact number |  |

**Mobility**

Do you have a long-term or permanent difficulty with mobility? No Yes

If yes, please give details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you need to use an aid? If yes, state what kind \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Smoking &/or Vaping**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Non Smoker |  | Ex-Smoker |  | Date of last smoke: | Currently Smoking (Inc. e-Cigarette) |  | How many per day? |  |
|  |  |  |  |  | Do you wish to stop? | N / Y If yes, our nurses will give you  further advise | | |

**Alcohol**

Do you drink alcohol? No Yes How many glasses per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diet (if procedure is today, please answer below)**

When have you last eaten? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ At what time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When have you last drunk?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ At what time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please tick all medical problems you have had in the past or present:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Heart, blood vessels and Blood disease** | | **Endocrine & Kidney** | | **GUT/ Liver** | |
| Hypertension |  | Diabetes Type 1 |  | Anaemia |  |
| Hypotension |  | Diabetes Type 2 |  | Change in Bowel Habit |  |
| Angina (diagnosed) |  | Implanted insulin pump |  | Constipation |  |
| High Cholesterol |  | Thyroid/hormone problems |  | Weight Loss |  |
| Atrial fibrillation (AF) |  | Kidney or urinary disease |  | Obesity |  |
| Heart Attack |  | Depression/Anxiety |  | Polyps |  |
| Heart Murmur |  | Alcohol Abuse |  | Ascites |  |
| Stroke |  | **Leg** | | Diverticular Disease |  |
| TIA ([Transient ischaemic attack](https://www.nhs.uk/conditions/transient-ischaemic-attack-tia/)) |  | Deep vein thrombosis (DVT) or blood clot(s) in leg |  | Inflammatory bowel disease (IBD)/Colitis/Crohns |  |
| ICD/Pacemaker |  | **Bones** | | Irritable bowel syndrome (IBS) |  |
| Heart surgery/heart stents |  | Arthritis or Rheumatoid Arthritis |  | Reflux |  |
| Bleeding or Clotting disorder |  | Osteoporosis |  | Stomach or duodenal ulcers |  |
| Rheumatic fever |  | Other musculoskeletal or joint conditions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Gallstones |  |
| Arteriosclerosis |  | **Eyes** | | Liver failure |  |
| Aneurysm |  | Cataracts |  | Cirrhosis |  |
| Immunodeficiency disorders |  | Glaucoma |  |  |  |
| Lupus |  | **Any prosthesis or metal plates in your body?** |  | If Yes, please tell us where  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **Brain** | | | | | |
| Fits/Epilepsy |  | Any memory problems in the last 12 months? |  | Seizures |  |
| Dementia |  | Bipolar disorder |  | Blackout/fainting |  |
| Drug Abuse: detail below \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Other mental issues  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Have you ever had a head and neck surgery, which has needed ICU admission or led to a nose/throat narrowing, or any other airway deformity?** | | |  | If yes, please specify:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Lungs** | | | | |  |
| Pulmonary embolism/Blood clot (s) in your lung |  | Cystic Fibrosis |  | Chronic bronchitis |  |
| Tuberculosis |  | COPD (Lung disease) |  | Do you use a portable oxygen? |  |
| Do you **SNORE LOUDLY** (louder than talking or loud enough to be heard through closed doors? |  | **Sleep apnoea/Were you ever told you stopped breathing on your sleep?** |  | If yes, do you need CPAP?  Do you have your CPAP with you today? |  |
| Asthma |  | **do you consider your asthma not under control? Have you had a recent attack (<1year), with need to be admitted in the hospital?** |  | **Do you feel short of breath when lying flat, using several pillows at night to sleep?** |  |
| **Any previous cancer/tumour?** If yes, please tell us which and what treatment you had/are having for it. | | | | | |
| **Any previous surgery?**  If yes, please tell us which. | | | | | |
| **Have you had a general anaesthetic or sedation before?** Yes No  **If yes, were there any problems/reactions/complications?** | | | | | |
| **Have you ever been informed that you have any infection, such as MRSA, Hepatitis, HIV or CJD (Mad Cow Disease)?**  If yes, please give details below. | | | | | |
| **Is there anything you would like to clarify or other conditions that we have not mentioned?** If yes, please write below. | | | | | |

**Pregnancy and Breastfeeding (women only)**

Is there any possibility you may be pregnant? No Yes

Are you breastfeeding? No Yes

**Medication**

Are you on any regular medication? No Yes

**Do you take any anticoagulants/blood thinners?** No Yes

**Do you take any steroids?** No Yes

|  |
| --- |
| Please write here the name and dose of your regular medication: |

# Image result for gstt logo