Bowen Hospital Health Questionnaire

BOWEN HOSPITAL

WAKEFIELD HEALTH

Personal Details (patient to complete and returned **before** admission)

PLEASE RETURN URGENTLY

Name ______ *Surname* ______ *Given names*

Date of Birth ______ Telephone ______ Height ______ *meters* Weight ______ *kg*

Address ______

Surgeon/Physician ______

Date of Surgery ______ Proposed Operation ______

- Please bring any x-rays with you when you come to the hospital
- If you are not filling out this questionnaire for yourself please state the reason why: (eg. Parent of a child) ....

PLEASE COMPLETE PAGES 1-3 ONLY

Do you have or have you ever had	YES	NO	COMMENTS
High blood pressure	☐	☐	....
Chest pain/Tightness or Angina	☐	☐	....
Heart attack	☐	☐	....
Palpitations or irregular heartbeat	☐	☐	....
Heart pacemaker	☐	☐	....
Artificial heart valves	☐	☐	....
Rheumatic heart disease	☐	☐	....
Other heart problems eg. heart murmur	☐	☐	*If YES please explain* ....
Asthma	☐	☐	....
Other lung problems	☐	☐	*if YES please explain* ....
Tuberculosis	☐	☐	....
Diabetes	☐	☐	....
Jaundice	☐	☐	*if YES please explain* ....
Hepatitis Type: A B C *(please circle)*	☐	☐	*if YES are you a carrier?* ....
Kidney problems	☐	☐	....
Prevous blood clots in the legs or lungs *(circle which)*	☐	☐	....
Blackouts or fainting	☐	☐	....
Epilepsy	☐	☐	....
Frequent indigestion or heartburn	☐	☐	....
Arthritis	☐	☐	....
Jaw, neck or back problems	☐	☐	*if YES where* ....

How long do you expect to stay in Bowen Hospital? Day case: YES / NO *(please circle)* .... Nights

Do you have or have you ever had:	YES	NO	COMMENTS
Severe snoring	☐	☐	....
Stop breathing during sleeping	☐	☐	....
Thyroid problems	☐	☐	....
Pituitary problems	☐	☐	....
Anaemia	☐	☐	....
Treatment for Cancer	☐	☐	....
Stroke or T.I.A	☐	☐	....
Muscle or nerve damage	☐	☐	....

General Questions	YES	NO	COMMENTS
Do you cough?	☐	☐	*If YES, do you bring up spit when coughing?* ....
Do you bruise or bleed easily?	☐	☐	....
Are you a haemophiliac?	☐	☐	....
Do you smoke?	☐	☐	*If YES, how many cigarettes a day?* ....
Did you ever smoke?	☐	☐	*If YES, what year did you stop?* ....
Do you drink alcohol regularly?	☐	☐	*If YES, how much a day?* ....
Females do you think you could be pregnant?	☐	☐	....
Do you suffer from motion sickness?	☐	☐	....

What physical activities do you take part in on a regular basis? (tick those that apply)

☐ Walking ☐ Gym work ☐ Tennis ☐ Golf ☐ Other

How many flights of stairs can you climb without getting out of breath?

☐ One flight ☐ Two flights ☐ Three flights or more

My activity is restricted by: ☐ Shortness of breath ☐ Chest pain ☐ Joint pain ☐ Other

Tablets/Medicines/Injections

Please list all medications taken in the last 8 weeks. (Including herbal and dietary supplements)

Medication	Amount	How often	Additional comments
....	....	....	....
....	....	....	....
....	....	....	....
....	....	....	....
....	....	....	....
....	....	....	....

Please bring all regular drugs in original pharmacy issue containers. (Including Herbal)

Allergies

List all allergies including reactions to drugs, lotions, sticking plaster, latex and foods. Please describe reaction.

....

....

....

....

....

Have you ever been admitted to Hospital?	YEAR	MONTH
If YES what for:	....	....
....	....	....
....	....	....

If you have been in any other hospital anywhere in the world within 6 months prior to your admission to Bowen it is very important we know this information. (Please read 'A bacteria known as MRSA' in the Bowen booklet)

Anaesthetics	YES	NO	COMMENTS
Have you ever had an anaesthetic?	☐	☐	....
1. Were there any problems? e.g. a bad reaction or nausea and vomiting	☐	☐	*If YES please state* ....
2. Do you have any problems with opening your mouth?	☐	☐	....
Are there any illnesses, to your knowledge among your blood relatives, eg: diabetes, muscular dystrophy, malignant hyperthermia?	☐	☐	....

Dietary needs	YES	NO	COMMENTS
Do you require a special diet?	☐	☐	....

Discharge arrangements	YES	NO	COMMENTS
Do you live alone?	☐	☐	....
Do you have any dependants?	☐	☐	....
Do you have difficulty dressing or bathing?	☐	☐	....
Do you have someone to take you home?	☐	☐	....
Do you have someone to stay with you or stay the night with you after you leave hospital?	☐	☐	....
Do you anticipate problems on discharge? What are they?	☐	☐	....
			....

ADDITIONAL INFORMATION FOR CHILDREN	YES	NO	COMMENTS
Was your child born prematurely?	☐	☐	....

Does your child have any breathing problems?	YES	NO	COMMENTS
Breath holding attacks or near-miss cot death?	☐	☐	....
Wheezing, coughing, or runny nose in the last 4 weeks?	☐	☐	....
Asthma?	☐	☐	....
Chronic or frequent breathing problems or infection?	☐	☐	....

NOTE: If within 10 days prior to admission you have any sort of infection; ie: flu, cold, broken areas or infected areas of the skin, vomiting/diarrhoea - please contact your surgeon.

PRE-OP CHECKLIST
FOR HOSPITAL STAFF USE ONLY

DATE:			SPECIAL ALERTS
GA LA SPINAL EPIDURAL IV SEDATION (Circle)			
	WARD	**THEATRE**	
SURGEONS CONSENT SIGNED			
ANAESTHETIC CONSENT SIGNED			
BLOOD CONSENT SIGNED			
BODY PARTS RQUESTED YES / NO			
PATIENT IDENTITY (ANKLE / WRIST)			
SKIN INTEGRITY			
OPERATION SITE MARKED			
ALLERGIES YES / NO IF YES SEE OVER			
PRE-MED GIVEN			
NORMAL MEDS TAKEN IF YES REFER TO DRUG CHART			
NBM SINCE			
CONTACT LENSES REMOVED			
GLASSES			
HEARING AIDS L/R			
DENTURES/CAPS/CROWNS/LOOSE TEETH			
SCREW/PLATE/PROTHESIS/IMPLANTS SITE:			
MRSA STATUS: KNOWN/UNKNOWN TYPE:			
HEPATITIS STATUS			
HIV STATUS: KNOWN/UNKNOWN			
JEWELLERY/BODY PIERCINGS SITE:			
ALL MAKE UP/NAIL VARNISH REMOVED			
OLD NOTES/X-RAYS			
TIME LAST PASSED URINE			
SIGNATURES:	WARD:	THEATRE:	