Ulladulla Endoscopy and Medical Centre

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www.ulladullaendoscopy.com.au

PRE-OPERATIVE QUESTIONNAIRE

Name:_____ DOB: _____

General Practitioner: _____ Location:_____

Health Insurance? Yes / No Pension? Yes / No

Please fill out this pre-operative form and return it to Ulladulla Endoscopy & Medical Centre at least 2 weeks prior to your surgery along with you GP letter.

General	YES	NO
1. Do you have any allergies? (list the type and reaction)	☐	☐
2. Do you (or have you ever) smoke? If yes, how many per day? ☐ ex-smoker	☐	☐
3. Do you drink alcohol? (how many / how often)?	☐	☐
4. Do you have an advanced care directive (living will) or "power of attorney" in place? If yes, please provide us a copy on or before your procedure date	☐	☐
5. Do you have dentures, crowns, or loose teeth?	☐	☐
Cardiovascular Risk	**YES**	**NO**
6. Do you have any heart trouble? e.g. chest pain, heart attacks, stents, AF, heart murmur, artificial heart valve, heart operations, pacemaker, or heart defects?	☐	☐
7. Do you have high blood pressure or other blood pressure problems?	☐	☐
8. Do you have breathing problems, e.g.: Asthma, Bronchitis, Emphysema, chronic cough, shortness of breath or other issues?	☐	☐
9. Can you walk up 10 stairs without stopping?	☐	☐
Health Screening	**YES**	**NO**
10. Do you have diabetes? If yes, what type?	☐	☐
11. Do you have thyroid disease?	☐	☐
12. Have you had a stroke or TIA?	☐	☐
13. Do you have a seizure disorder or epilepsy?	☐	☐
14. Do you have any other serious illnesses or panic disorders/phobias? If yes, please provide details	☐	☐
15. Are you currently pregnant or breastfeeding?	☐	☐

Previous Procedures	YES	NO
16. Have you had any previous surgeries? If yes, please provide details	☐	☐
17. Have you or anyone in your family had anaesthetic problems? If yes, please provide details	☐	☐
18. Do you have any joint replacements or metal plates / screws in your body?	☐	☐
Falls Risk	**YES**	**NO**
19. Do you use a walking stick or walking frame?	☐	☐
20. Do you get dizzy or lose balance easily?	☐	☐
21. Do others tell you that you are unsteady on your feet?	☐	☐
22. Do you take medication that leaves you disorientated?	☐	☐
23. Have you had a fall in the last 3 months?	☐	☐
Pressure Injury Risk	**YES**	**NO**
24. Have you ever had a pressure injury or bed sore?	☐	☐
25. Do you find that your skin bruises or tears easily?	☐	☐
26. Do you require assistance to change position or get in and out of a chair or bed?	☐	☐
27. Do you currently have anaemia?	☐	☐
Infection Risk	**YES**	**NO**
28. Do you have an artificial heart valve, heart murmur or recent surgery?	☐	☐
29. Do you have hepatitis or HIV?	☐	☐
30. Have you ever had MRSA, Golden Staph, C. Difficile diarrhoea, CRE or VRE?	☐	☐
Bleeding Risk	**YES**	**NO**
31. Are you on Warfarin, Plavix, Xarelto, Pradaxa, Cartia or other blood thinners?	☐	☐
Medications	**YES**	**NO**
32. Do you take any regular medications? If yes, please list them including dose and frequency	☐	☐
PLEASE SUPPLY YOUR ☐ ECG ☐ BLOOD TESTS ☐ GP LETTER		