Ulladulla Endoscopy and Medical Centre
111 Princes Highway, Ulladulla, NSW, 2539
Tel: 02 4455 5422 Fax: 02 4454 2263

(Affix Patient Label)
Name:
DOB:
MRN:

PRE-OPERATIVE QUESTIONNAIRE

Name: _____ DOB: _____

General Practitioner: _____ Location: _____

Health Insurance? Yes / No_____ Pension? Yes / No HCC? Yes / No

History		YES	NO
1. What matters most to you for this admission?			
2. Do you have any allergies/adverse reactions to medicines, foods, chemicals, substances including Latex? (list the type and reaction)		☐	☐
3. What is your current weight and height?	Weight	Height	
4. Do you have dentures, crowns, loose teeth, dental issues, etc? (please circle or list)		☐	☐
5. 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		☐	☐
6. Do you have a Substitute Decision Maker?		☐	☐
7. Do you (or have you ever) smoke(d)? If yes, how many per day? ☐ ex-smoker		☐	☐
8. Do you drink alcohol? (how many / how often)?		☐	☐
Cardiovascular Risk		**YES**	**NO**
9. 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? (please circle or list)		☐	☐
10. Do you have high blood pressure or other blood pressure problems?		☐	☐
Breathing Issues		**YES**	**NO**
11. Do you have breathing problems, e.g.: Asthma, Bronchitis, Emphysema, chronic lung disease, obstructive sleep apnoea, etc.? (please circle or list)		☐	☐
12. Do you get shortness of breath in normal activities (require rest breaks)?		☐	☐
Health Screening		**YES**	**NO**
13. Do you have diabetes? If yes, what type?	☐ Insulin Dependent? ☐ Non-Insulin Dependent?	☐	☐

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	YES	NO
14. Do you have anaemia?	☐	☐
15. Do you have thyroid disease?	☐	☐
16. Have you had a stroke or TIA or other neurological issues?	☐	☐
17. Do you have epilepsy or Parkinson's or another seizure disorder?	☐	☐
18. Do you have any Mental health issues, including suicidal thoughts, self-harming behaviours, anxiety, or any phobias? (please circle or list)	☐	☐
19. Do you have any other serious illnesses or other health issues that may impact on your procedure? If yes, please provide details	☐	☐
20. Are you currently pregnant or breastfeeding?	☐	☐
Previous Procedures	**YES**	**NO**
21. Have you had any previous surgeries? If yes, please provide details	☐	☐
22. Have you or anyone in your family had anaesthetic problems? If yes, please provide details	☐	☐
23. Endoscopy Patients only - Have you had any endoscopic procedures in the past, e.g. gastroscopy, colonoscopy?	☐	☐
24. Endoscopy Patients only - Do you have any family history of bowel cancer or bowel polyps?	☐	☐
25. Do you have any joint replacements/metal plates/pins/screws or implants/devices in your body?	☐	☐
Comprehensive Care Plan	**YES**	**NO**
26. Do you fall over easily?	☐	☐
27. Do you use a walking stick or walking frame?	☐	☐
28. Have you had a pressure sore before? If yes, give details	☐	☐
29. Have you ever had a blood clot before (DVT, PE)? If yes, give details	☐	☐
30. Do you take warfarin or other blood thinners? If yes, give details	☐	☐
31. Are you on any special diet? If yes, give details	☐	☐
32. Do you have any problems with memory or dementia?	☐	☐
33. Do you take medication that leaves you disorientated?	☐	☐

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	YES	NO
34. Have you had delirium in hospital before?	☐	☐
35. Do you have a reliable adult to stay with you for 24 hours after your operation? (NB: Failure to have a suitable adult to stay with you may result in cancellation of your procedure)	☐	☐
Infection Risk	**YES**	**NO**
36. Do you currently have any type of infections? If yes, give details	☐	☐
37. Have you been exposed to a person with an infectious disease in the past 2 weeks e.g. chickenpox, measles, etc.?	☐	☐
38. Have you recently had surgery?	☐	☐
39. Have you had MRSA (golden staph); Hepatitis or HIV?	☐	☐
40. Have you recently returned from overseas in the past 4-6 weeks? If yes, where?	☐	☐
41. Have you been hospitalised overseas in the last 12 months? If yes, give details	☐	☐
Cataract Patients only - Screening Question	**YES**	**NO**
42. Do you have Creutzfeld-Jacob Disease (CJD)?	☐	☐
43. Have you had two or more first or second degree relatives with CJD?	☐	☐
44. Have you experienced an unexplained progressive neurological illness of less than 12 months?	☐	☐
45. Do you have a history of receiving human pituitary hormone for infertility or human growth hormone for short statue prior to 1986?	☐	☐
46. Have you previously had surgery on the brain or spinal cord that included a dura mater graft prior to 1990?	☐	☐
47. Have you been involved in a "look-back" for CJD or shown you a "medical in confidence" letter regarding their risk for CJD?	☐	☐
48. Have you had a dura mater graft prior to 1990?	☐	☐

Continued over

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Medications	YES	NO
49. Do you take any regular medications? If yes, give details including dose and time taken	☐	☐

Name of Person Completing this form:	Signature:
	Date:

Cataract, Dental, Skin Cancer and/or Vascular Patients only:

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

PLEASE SUPPLY YOUR ☐ ECG ☐ BLOOD TESTS ☐ HEALTH SUMMARY (From GP) ☐ MEDICATION LIST