This form is to help us find out more about you and your health so that we can think about what help you might need to help you get ready for your operation.

It’s ok if you can’t answer all the questions on the form, just answer as many as you feel you are able to.

If you need any help with this form or would like it in large print or other languages, please call [insert phone number and when service is open].

#### 1. Your personal details

|  |  |
| --- | --- |
| Name |  |
| NHS number |  |
| Hospital number |  |
| Date of birth |  |

#### 2. About you (please circle the answer that applies to you)

|  |  |
| --- | --- |
| Would you say your health is… | Very goodGoodFairSometimes good and sometimes poorPoor |
| Are you currently working?  | Yes/NoIf yes, what is your job? |
| Do you have a physical disability or impairment? | Yes/NoIf yes, please tell us more. |
| Do you have a learning disability? | Yes/No/UnsureIf yes, please tell us more.If yes, have you had your annual health check?Yes/No/Unsure |
| Do you have a diagnosis of a serious mental health condition, such as schizophrenia, psychosis or bipolar disorder? | Yes/No/Unsure If yes, please tell us more.If yes, have you had your annual health check?Yes/No/Unsure |

3. Have you had surgery before?
If yes, please answer the questions below. If no, please go to the next section.

|  |  |  |
| --- | --- | --- |
| Have you had a general anaesthetic (gone to sleep for surgery or procedure) before? | Yes/No/Unsure | If yes:* When did you last have a general anaesthetic?month (if known)/year
* Did you have any problems or side effects at the time or afterwards?No/Yes

If yes, please tell us more. |
| Please use this space for anything else you would like to tell us about your previous experience of surgery or anaesthesia.  |  |

4. About your long-term health

This part of the form is about any long-term health conditions or health issues you might have. We need to know about these so that with you we can plan how to make your surgery as safe as possible and how we can help you to recover as quickly as possible.

|  |  |  |
| --- | --- | --- |
| Are you prescribed regular medications | Yes/No |  |
| Other than the condition for which you are having surgery, do you have any health conditions which you see your GP or a hospital service for? | Yes/No |  |
| Over the past 2 weeks, has pain stopped you doing the things you normally do? | Yes/No |  |
| Were you told you had to shield during the Covid pandemic? | Yes/No/Unsure |  |
| Do you have long Covid? | Yes/No/Unsure |  |
| Do you have diabetes?  | Yes/No/Unsure | If yes, please tell us how your diabetes is managed (circle all that apply):Diet onlyTabletsInsulinPlease tell us the names of the medicine(s) you are taking.  |
| Do you have anaemia or heavy blood loss (eg from menstrual periods)? | Yes/No/Unsure | If yes, are you taking any medicine for this?Yes/NoIf yes – what medicines are you taking?* Iron tablets – Yes/No/Unsure
* Iron injections – Yes/No/Unsure
* Vitamin B12 injections (usually every 3 months) – Yes/No/Unsure
* Folic acid tablets – Yes/No/Unsure
 |
| Do you have a heart condition that requires a regular review or that seems problematic to you? | Yes/No/Unsure | If yes: are you under the care of a heart specialist? (cardiologist)Yes/No/UnsureName of hospital/Trust: |
| Do you have a lung condition that requires a regular review or that seems problematic to you? | Yes/No/Unsure | If yes: are you under the care of a lung or breathing specialist? (respiratory physician)Yes/No/UnsureName of hospital/Trust: |
| Do you have any problems with your liver? | Yes/No/Unsure |  |
| Do you have any problems with your kidneys?  | Yes/No/Unsure |  |
| Have you ever had a blood clot in the lung or leg? | Yes/No/Unsure |  |
| Have you ever had a stroke, mini-stroke or other problem affecting your brain | Yes/No/Unsure |  |
| Please use this space to tell us anything else about your long-term health. |

#### 5. About your weight

This section asks about your weight. This information helps us identify what support you may need ahead of your surgery, as being under or overweight can make surgery more difficult and recovery longer.

|  |  |
| --- | --- |
| Your height and weight (if you know). | My height is ….(in feet/inches or metres/centimetres)My weight is ….(in stones/pounds or kilograms) |
| Have you lost weight in the last 6 months without trying to do so? | Yes/No |
| Are you having any problems eating enough to keep weight on? | Yes/NoIf yes, please tell us more. |

#### 6. About your day-to-day life

|  |  |  |
| --- | --- | --- |
| **Are you able to:** | **Yes**  | **No** |
| Take care of yourself (eg eating, dressing, bathing, using the toilet)? |  |  |
| Walk around indoors at home? |  |  |
| Walk for about 5 minutes or one or two streets on level ground? |  |  |
| Walk for 20 to 30 minutes or about a mile on level ground? |  |  |
| Climb a flight of stairs or walk up a hill? |  |  |
| Run a short distance? |  |  |
| Do light housework (e.g. dusting, washing dishes)? |  |  |
| Do moderate housework (e.g. hoovering, sweeping floors, carrying in shopping)? |  |  |
| Do heavy housework (e.g. scrubbing floors, lifting or moving heavy furniture)? |  |  |
| Do gardening (eg raking leaves, weeding, pushing a lawn mower) or activities such as painting and decorating, DIY whether at work or around the house? |  |  |
| Have sexual relations? |  |  |
| Participate in moderate recreational activities, e.g. going for a brisk walk, cycling gently or on level ground, gentle swimming, golf, bowling, dancing, doubles tennis, having a gentle kick about in the park? |  |  |
| Participate in strenuous sports, e.g. jogging or running, cycling fast or up hills, playing football, aerobics, fast swimming, skiing, singles tennis or basketball? |  |  |

#### 7. Alcohol

|  |  |
| --- | --- |
| How often do you have an alcoholic drink? | NeverMonthly or less frequently2–4 times a month3 or 4 times a week4+ times a week |
| How many units do you drink on a typical day when you are drinking?(1 unit = ½ a glass of wine, ½ a pint of beer or 1 short of spirit) | 1–23–45–67–910+ |

#### 8. Smoking

|  |  |  |
| --- | --- | --- |
| Do you smoke or use tobacco in any other form? | Yes/No |  |
| Have you ever smoked? | Yes/No | If yes, when did you quit? (month/year if possible) |

#### 9. Please use this space to tell us anything else you would like us to know about you or your health.

|  |
| --- |
|  |

Thank you for taking the time to complete this form.