KING EDWARD VII's HOSPITAL

Health Assessment

Pre-operative assessment (POA)
Beaumont Street
London W1G 6AA
Telephone: 0207 467 4320/4338
Facsimile: 020 7467 4352
Email:preadmissionclinic@kingedwardvii.co.uk

Please complete and return this form as soon as possible in the pre-paid envelope provided in person at your POA appointment, by fax or by email. The information you provide will ensure we meet your needs and will help us to assess your fitness for surgery and anaesthesia. Any information provided by you is treated in the strictest professional confidence. **Please provide your title & name details as they appear on official documents such as your passport or driving licence.**

Title _____ **Surname** _____

First Name _____ **Middle Name** _____

DOB _____ **Age** _____ **Gender** _____

Have you been a patient at King Edward VII Hospital before? Y ☐ N ☐

If you require any support to read or understand the information we send you, or additional support to attend your hospital appointment please let us know.

Pre admission MRSA screening is required by King Edward VII Hospital for most patients. Please call 0207 467 4320 / 4338 or email for instructions. Please contact the POA immediately if you have had MRSA.

1. What is the **reason for this admission to hospital?** If applicable, please specify operation and which side (i.e. left hernia repair / right knee surgery)

Date of admission (if known):

2. Do you have any of the following **important health conditions?** Y ☐ N ☐
If yes, please tick the box and add more information as necessary.
*Please attach a copy of your pacemaker passport to this form so that a pacemaker check can be arranged if necessary.

HEALTH CONDITION		PLEASE SPECIFY
Previous MRSA		
High blood pressure (hypertension)		
Abnormal heart rhythm (Arrhythmia)		
*If you have a Pacemaker / ICD (last checked __/__/__)		
Coronary stent / angioplasty		
Asthma		
COPD (bronchitis / emphysema)		
Problems sleeping (insomnia, sleep apnoea)		
Depression / anxiety		
Phobia of any kind		
Under / over active thyroid		
Jaundice (liver problems)		
Blood clot in your leg (DVT)		
Blood clot in your lung (PE)		
Fits (Epilepsy) (last episode __ /__/__)		
Stroke (CVA/TIA)		
Memory problems		
Arthritis		
Joint problems		
Diabetes		
Cancer		
Blood disorders		
Sickle cell or trait		
Stomach / bowel problems		
Kidney / bladder problems		
MI (heart attack)		

Patient Label

3. Have you had any **previous operations?** Y ☐ N ☐
If yes, please list below.

Surgical procedure	Year

4. Have you previously had an **anaesthetic?** Y ☐ N ☐

If yes, have you had any **difficulties with anaesthesia?** Y ☐ N ☐

If yes, please indicate below with a tick, and give details as appropriate.

Severe nausea or vomiting		Difficult insertion of breathing tube	
Allergic reaction (skin/breathing)		Severe reaction to anaesthetic drugs (rare)	
Blood relatives had a major complication with anaesthesia		Other	

5. Do you take prescription **medications** or herbal supplements? Y ☐ N ☐
If yes, please list all prescription **medications,** over–the-counter medications and herbal supplements that you take **OR attach a copy of your prescription medications.** Please note that we are unable to use your medication from a monitored dosage system i.e. Dosette ®. We will use your own medications from original labelled containers whilst you are in hospital. Please bring these with you on admission.

Name of medication	Strength of medication	How often you take this medication

6. Do you take drugs that affect your **blood clotting**? For example, Aspirin / Warfarin / Apixaban / Plavix (Clopidogrel) / long term non-steroidal anti-inflammatory drugs (Ibuprofen, Nurofen, Naproxen, and Voltarol) / Dabigatran / Rivaroxaban / Oestrogen based contraceptives / Hormone Replacement Therapy? Y ☐ N ☐

If yes, please ensure that your consultant is aware & indicate here any instructions you have been given about stopping this medication, including the date you are to stop. If taking Warfarin, please bring your Yellow Book with you to hospital.

Name of Drug/s: _____ Date to STOP Drug: _____

Patient Label

7. **For women:**

   1. Are you pregnant? Y ☐ N ☐

   2. Date of last menstrual period (LMP) __/___/___

   3. If you have recently had a baby, is it more than 6 weeks ago? Y ☐ N ☐

8. Current **weight** _____ kg / lbs. Current **height** _____ cm / ft. inches BMI = _____ (office use only)

9. Do you have **known allergies to medication or other substances?** (Penicillin/Contrast dye/*Latex rubber) N ☐

   If yes, please list below.

   *If you have an allergy to LATEX, and are unable to return this form prior to admission, please contact the Pre Admission Clinic ASAP.

Name of medication / substance	How do you react to this medication/substance? (i.e. Nausea / Rash / Itching)

10. Do you have any of the following **food allergies?** N ☐

    If yes, please specify which foods and reaction.

    _____

    _____

11. Do you require a **special diet?** Y ☐ N ☐ Chef Notified ____ (office use only)

    If yes, please indicate below with a tick.

Diabetic		Vegetarian		Dairy free	
Kosher		Gluten free		Lactose free	
Halal		Wheat free		Vegan	
Soft diet		Thickened fluids / pureed diet		Other	

12. Have you been out of the UK in the past 12 months? Y ☐ N ☐

    If yes, where did you travel? _____

    _____

    While you were abroad, did you visit a hospital or receive medical treatment? N ☐

    If yes, please give brief details _____

    _____

    _____

Patient Label

13. Do you require **additional support / assistance** or use any **special equipment?** Y ☐ N ☐

If yes, please indicate below with a tick, and please inform us of how we can best support you during your hospital stay.

Personal care		Toileting		Dressing		Eating		Commode	
Glasses		Hearing aid		Contact lenses		Prosthesis			
Wheel chair		Frame		Walking stick		Crutches			
Hearing loss		Visual Impairment		Learning difficulty					

14. Do you have a *__carer and/or nursing care at home?__ Y ☐ N ☐

If yes, how often is your carer with you? _____ Will they be accompanying you? Y ☐ N ☐

*If you have a 24 hour carer and/or nursing care at home we prefer that they accompany you during your hospital stay, as the nursing care provided is not 1:1 at the hospital.

15. Do you need an **interpreter?** Y ☐ N ☐

If yes, please give details of language:_____

16. Do you **smoke?** Y ☐ N ☐ _____ per day

_____ years

Do you drink **alcohol?** Y ☐ N ☐ _____ units/week

Do you use recreational **drugs?** Y ☐ N ☐

If YES, please specify:

Rough guide to measurements:

Half pint of ordinary strength beer /lager /cider (4-6% ABV) = 1 UNIT
A 25ml pub measure of spirit (40% ABV) = 1 UNIT
A small glass of wine (12-14% ABV) = 1 UNIT

17. Do you have an *__Advance Healthcare Directive?__ Y ☐N ☐

*An **advance** healthcare **directive**, also known as living will, **personal directive, advance directive,** medical **directive or advance** decision, is a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity.

Please notify your Consultant as soon as possible if your health condition changes (e.g. you develop a cold or infection) or you need to cancel your appointment for any reason.

Please be aware that the time of discharge is 11am if you have stayed overnight.

Date & Time _____ **Completed by** _____

Date & Time _____ **Reviewed by POA**_____

Date & Time _____ **Reviewed on Admission by** _____

Note: Admitting nurse MUST review this with patient on Admission. Any additions/changes to be dated timed & initialled.