KING EDWARD VII's HOSPITAL

Health Assessment

Pre-operative assessment (POA)

Beaumont Street, London W1G 6AA
Tel: 0207 467 4338 or 0207 467 4320
Email: preadmissions@kingedwardvii.co.uk
Website: kingedwardvii.co.uk

Patient Label

Please complete by typing in the boxes, save the document and return by email to preadmissions@kingedwardvii.co.uk as soon as possible. Alternatively, you can print the completed form and send by post to Pre-operative assessment, 5-10 Beaumont Street, Marylebone, London, W1G 6AA or bring with you to your pre-assessment appointment.

1. Your details

Title

How would you like to be addressed/ preferred name?

Surname

DOB (DD/MM/YY)

Forename

Age

Biological sex Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Other

Gender identity Male ☐ Female ☐ Non-binary ☐ Other

Religion

2. Your admission

Date of admission (if known)

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

Day case or overnight?

Have you been a patient at KEVII Hospital before? Yes ☐ No ☐

Next of kin

Relationship

Contact details

3. Interpreter

Do you need an interpreter? Yes ☐ No ☐

If YES, which language?

5. COVID vaccine

Have you had your 1st vaccine dose? Yes ☐ No ☐ If YES, what was the date?

Have you had your 2nd vaccine dose? Yes ☐ No ☐ If YES, what was the date?

Have you had your booster? Yes ☐ No ☐ If YES, what was the date?

Type of vaccine

Have you ever had COVID-19? Yes ☐ No ☐ If YES, what was the date of your illness?

6. Allergies

Do you have known allergies to medication, food, or other substances? (e.g. contrast dye, latex rubber) Yes ☐ No ☐

If YES, please list on the next page. If you have an allergy to latex, please let the pre-assessment nurse know.

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6. Allergies (ctd)

Name of medication / substance you are allergic to	How you react to this medication / substance

7A. Health conditions - Heart or blood pressure

Do you have or have you ever had any problems with your heart or blood pressure? Yes ☐ No ☐

If NO go to section 7B. If YES please tick all that apply and give details below:

High blood pressure	☐	
Heart attack	☐	
Palpitations or irregular heart beat	☐	
Pacemaker / ICD fitted	☐	
Coronary stent / angioplasty	☐	
Chest pain / angina	☐	
Heart failure	☐	
Mechanical heart valve	☐	
Atrial fibrillation	☐	
Heart murmur	☐	
Further details		

7B. Health conditions - Lungs or breathing

Do you have or have you ever had any problems with your lungs or breathing? Yes ☐ No ☐

If NO go to section 7C. If YES please tick all that apply and give details below:

Asthma	☐	
Chronic obstructive pulmonary disease (COPD)	☐	
Shortness of breath	☐	
Breathlessness on lying flat	☐	

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7B. Health conditions - Lungs or breathing (ctd)

Pneumonia / bronchitis / emphysema	☐	
Sleep apnoea	☐	
Further details		

7C. Health conditions - blood circulation

Do you have or have you ever had any of the following problems with your blood or circulation? Yes ☐ No ☐

If NO go to section 7D. If YES please tick all that apply and give details below:

Problems with circulation	☐	
Blood clot in leg (DVT)	☐	
Blood clot in lung (PE)	☐	
Blood disorders including bruising / bleeding	☐	
Sickle cell carrier / trait	☐	
Blood infections e.g. Hepatitis / HIV	☐	

7D. Health conditions - other

Do you have or have you ever had any of the following problems? Yes ☐ No ☐

If NO go to question 8. If YES please tick all that apply and give details below:

Stroke (CVA or TIA)	☐	
Epilepsy or seizures	☐	
Neurological condition	☐	
Under-/overactive thyroid	☐	
Diabetes type I or II	☐	
Jaundice / liver problems	☐	
Iron Deficiency Anaemia	☐	
Diagnosed or treated cancer	☐	
Kidney / urinary problems	☐	
Gastric / bowel problems	☐	
Heartburn, hiatus hernia, or peptic ulcer (reflux)	☐	
Problems sleeping	☐	

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7D. Health conditions - other (ctd)

Memory problems (Dementia, Alzheimer's)	☐	
Joint problems	☐	
Arthritis	☐	
Phobia of any kind	☐	
Previous positive MRSA infection	☐	
Chronic pain	☐	
Anxiety or depression	☐	
Further details or any other medical issues not listed above		

8. Falls

Have you fallen within the last 12 months? Yes ☐ No ☐ If YES, on how many occasions?

Please give details of any injuries sustained below:

9. CJD

Have you or anyone in your family been diagnosed with or died from Creutzfeldt-Jakob disease (CJD)? Yes ☐ No ☐

Have you ever received a letter from the Department of Health informing you that you have been put at risk of contracting CJD after receiving blood from someone who later died of CJD? Yes ☐ No ☐

10. Operations

Have you had any previous operations? Yes ☐ No ☐

If YES, please list below:

Procedure	Year

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11. Anaesthetic

Have you or any of your family ever had a problem with a general anaesthetic? Yes ☐ No ☐

If YES, please give details below:

12. Medications

Do you take any prescription medications or herbal supplements? Yes ☐ No ☐

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 bring all your medications in the original packaging to your pre-assessment and when you come into hospital for admission. We are unable to use your medication from a monitored dosage system, e.g. Dosette box.

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

13. Blood clotting

Do you take any drugs that affect your blood clotting? Yes ☐ No ☐

For example: Aspirin / Warfarin / Apixaban / Plavix (Clopidogrel) / Dabigatran / Rivaroxaban; Long-term non-steroidal anti-inflammatory drugs (Ibuprofen, Nurofen, Naproxen, Voltarol); Oestrogen-based contraceptives/ Hormone replacement

If YES, please ensure that your consultant is aware and 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(s)

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14. Pregnancy (if applicable)

Are you currently pregnant? Yes ☐ No ☐

Have you had a baby within the last six weeks? Yes ☐ No ☐

15. Further details

Do you wear glasses or contact lenses? Yes ☐ No ☐

Do you wear hearing aids? Yes ☐ No ☐

Do you have any physical disability? If YES, please give details below: Yes ☐ No ☐

Do you have a hidden disability or any other special needs? If YES, please give details below: Yes ☐ No ☐

16. Diet

Do you require a special diet? Yes ☐ No ☐

If YES, please indicate below:

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

17. Weight loss

Current weight kg / lbs

Current height cm / ft. in.

Have you lost weight in the previous 3-6mths? Yes ☐ No ☐

Amount lost

If YES, was this intentional? Yes ☐ No ☐

18. Overseas travel

Have you been out of the UK in the past 12mths? Yes ☐ No ☐

If YES, where did you travel?

While you were abroad, did you visit a hospital or receive medical treatment? Yes ☐ No ☐

If YES, please provide brief details below:

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19. Exercise tolerance

Can you walk up two flights of stairs? Yes ☐ No ☐

If you answered NO, are you limited by the following? (tick all that apply)

Pain / Arthritis ☐ Breathlessness ☐ Angina or chest pain ☐

Please add notes below:

20. Smoking

Do you smoke? Yes ☐ No ☐ How many years have you smoked?

If YES, how many cigarettes do you smoke per day?

Are you an ex-smoker? Yes ☐ No ☐ When did you give up smoking?

Do you have a chronic cough? Yes ☐ No ☐

21. Alcohol

Do you drink alcohol? Yes ☐ No ☐

If YES, how many units per week?

1 UNIT = approx. a half-pint of ordinary strength beer/lager/cider (4-6%ABV), 25ml pub measure of spirit (40%ABV), or a small glass of wine (12-14%ABV).

22. Recreational drugs

Do you use recreational drugs? Yes ☐ No ☐ If YES, please specify

23. Advance Healthcare Directive

Do you have an 'Advance Healthcare Directive'? Yes ☐ No ☐ If YES, please advise your consultant

24. Discharge planning

Are you aware of anything that may delay your discharge for example transport, facilities at home? Yes ☐ No ☐

We kindly ask that you make plans to be collected at 10am on the day of your discharge if you have stayed overnight unless there is some medical or other reason for you to stay.

The following information will assist us with planning your discharge from hospital.

Do you live in a House ☐ Bungalow ☐ Flat ☐ Does your home have stairs? Yes ☐ No ☐

Do you use a walking aid or wheelchair? Yes ☐ No ☐ Stairs to front door? Yes ☐ No ☐ Number ☐

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24. Discharge planning (ctd)

Do you have a walk-in shower? Yes ☐ No ☐

Internal stairs? Yes ☐ No ☐ Number ☐

Is there a toilet downstairs? Yes ☐ No ☐

Do you currently use community services (social services, community nurse, meals on wheels etc)? Yes ☐ No ☐

Who will be looking after you when you go home?

Please give any other relevant information you feel we should know:

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 NOTE: If you are having sedation or general anaesthetic as a day case you will need to arrange for someone to escort you home and stay with you overnight.

Patient

Date

Completed by

Date

FOR COMPLETION BY THE PRE-OPERATIVE ASSESSMENT TEAM

Signature ..... Date .....

FOR COMPLETION BY NURSING TEAM

No changes since pre-operative assessment ☐

Changes since pre-operative assessment, documented in the ICP ☐

Signature ..... Date .....