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

Last amended 27 August 2025. Version 4.4

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

Surname

Forename

How would you like to be addressed/ preferred name?

DOB (DD/MM/YY)

Age

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

Gender identity Male ☐ Female ☐ Non-binary ☐ Other

Religion

Profession

Contact No.

2. Your admission

Date of admission (if known)

Day case or overnight?

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

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

Next of kin

Relationship

Contact details

3. Interpreter

Do you need an interpreter? Yes ☐ No ☐

If YES, which language?

4. Vaccinations

Have you had any vaccinations in the last 2 weeks Yes ☐ No ☐

If YES, type of vaccine and the date of dose?

Have you had COVID-19 or any other viral infections within the last month Yes ☐ No ☐

If YES, symptoms and what was the date of your illness?

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5. Allergies and Sensitivities

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.

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

6. 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 on your admission to hospital. We are unable to use your medication from a monitored dosage system, e.g. Dossette box.

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

6b. 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 _____ Date to stop _____

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6c. SGLT-2 Inhibitor

Do you take any SGLT-2 inhibitors (e.g. ***Dapagliflozin, Canagliflozin, Empagliflozin, Ertugliflozin***) to manage your Diabetes? Yes ☐ No ☐

If YES, please specify

6d. GLP-1 Agonists

Do you take any GLP-1 Agonists (eg. Ozempic, Wegovy, Mounjaro, Saxenda, Trulicity, Rybelsus, Zepbound) If YES, please which drug

It is important that your SGLT-inhibitor and GLP-1 is omitted before your surgery. You will receive Consultant specific advice from the Pre-Assessment Team for when you need to start omitting these medications.

6e. Recreational drugs

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

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	☐	
Pneumonia / bronchitis / emphysema	☐	
Sleep apnoea	☐	
Further details		

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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	☐	
Leg /pressure ulcers or open wounds	☐	

Have you had Blood Transfusion before? Yes ☐ No ☐

If yes, have you experienced any reactions? Yes ☐ No ☐

Did you require any special blood products? No ☐ CMV Negative ☐ Irradiated Components ☐ HEV Negative ☐

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	☐	
Memory problems (Dementia, Alzheimer's)	☐	

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7d. Health conditions - other (ctd)

Joint problems	☐	
Arthritis	☐	
Phobia of any kind	☐	
Previous positive MRSA infection	☐	
Carbapenem-resistant Enterobacteriaceae (CRE)	☐	
Vancomycin-resistant Enterococci (VRE)	☐	
Clostridium difficile (C.diff)	☐	
Extended Spectrum Beta-Lactamase (ESBL)	☐	
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	Month	Year	Hospital

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11. Recent Hospital Attendance or Admission

Have you been in a hospital within the last six months and stayed 48hrs or more? ☐ Yes ☐ No

If YES, please list below:

Reason for Visit / Admission	Year/Hospital

12. Anaesthetic

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

If YES, please give details below:

13. Pregnancy (if applicable)

Are you currently pregnant? Yes ☐ No ☐

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

14. 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 ☐

15. 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	

16. Fasting instructions

Has your surgeon given you any fasting instructions? Yes ☐ No ☐

Please give details

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17. Weight loss

Current weight

Current height

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:

19. Mobility

Do you use a walking aid or wheelchair? Yes ☐ No ☐

20. Exercise tolerance

Do you regularly exercise, if yes please document what and how often

Can you walk more than 10 minutes at a moderate pace without stopping? Yes ☐ No ☐

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 ☐

21. 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 ☐

22. 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).

23. Advance Healthcare Directive

Do you have an 'Advance Healthcare Directive'? Yes ☐ No ☐

If YES, please advise your consultant

(A document outlining your preference for medical treatment)

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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 ☐

Do you use a walking aid or wheelchair? Yes ☐ No ☐

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

Is there a toilet downstairs? Yes ☐ No ☐

Stairs to front door? Yes ☐ No ☐ Number ☐

Internal stairs? Yes ☐ No ☐ Number ☐

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

Relationship

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 .....