|  |  |  |
| --- | --- | --- |
| Patient MRN/NHS  **Click here to add comment** |  | Patient name: **Click here to add comment** |
|  | Date of birth: **Click here to add comment** |
|  | Date form completed: **Click here to enter a date.** |

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| **HEALTH SCREENING QUESTIONNAIRE** | | | | | | | | | | | | | | |
| **Communication** | | | | | | | | | | | | | | |
| 1. | | Preferred Language? Click here to add comment | | | | | | | | | | | | |
| 2. | | Interpreter Required? If yes what language? Click here to add comment | | | | | | | | | Yes | | No | |
| 3. | | Happy use telephone interpreter service?  Click here to add comment | | | | | | | | | Yes | | No | |
| 4. | | Hearing impairment? | | | | | | | | | Yes | | No | |
| 5. | | Do you use hearing aids? | | | | | | | | | Yes | | No | |
| 6. | | Do you require a British Sign Language interpreter? | | | | | | | | | Yes | | No | |
| 7. | | Any Visual Impairment? If yes please describe impairment.  Click here to add comment | | | | | | | | | Yes | | No | |
| 8. | | Any difficulties being understood? If yes how can we help in the appointment? Click here to add comment | | | | | | | | | Yes | | No | |
| 9. | | Any Physical Impairment? If yes please describe below if you use an aid e.g. a wheelchair  Click here to add comment | | | | | | | | | Yes | | No | |
| 10. | | Do you require hospital transport? Click here to add comment | | | | | | | | | Yes | | No | |
| **Have you ever had or do you have any of the following?** | | | | | | | | | | | | | | |
| **Cardiovascular** | | | | | | | | | | | | | | |
| 1. | | Angina (chest pain when exercising or at night) or severe pain across the front of your chest lasting 30 minutes or more? Click here to add comment | | | | | | | | | Yes | | No | |
| 2. | | A heart attack? Click here to add comment | | | | | | | | | Yes | | No | |
| 3. | | A pacemaker, an irregular heartbeat or abnormal pulse, or heart-block?  Click here to add comment | | | | | | | | | Yes | | No | |
| 4. | | A diagnosis of heart failure, cardiomyopathy, a heart murmur or rheumatic fever? | | | | | | | | | Yes | | No | |
| 5. | | Uncontrolled high blood pressure? *(please tick Yes if you take medication for high blood pressure)* Click here to add comment | | | | | | | | | Yes | | No | |
| 6. | | Unexplained blackouts (fainting) or severe dizziness? Click here to add comment | | | | | | | | | Yes | | No | |
| 7. | | A stroke (cerebrovascular accident – CVA) or Transient Ischaemic Attack (TIA)?  Click here to add comment | | | | | | | | | Yes | | No | |
| 8. | | Any significant blood disorders (sickle cell anaemia, haemophilia, excessive bleeding or bruising)? Click here to add comment | | | | | | | | | Yes | | No | |
| 9. | | Blood clots, deep vein thrombosis (DVT) or pulmonary embolism (PE)?  Click here to add comment | | | | | | | | | Yes | | No | |
| 10. | | Recent blood clots (within 3 months)? Click here to add comment | | | | | | | | | Yes | | No | |
| **Respiratory** | | | | | | | | | | | | | | |
| 11. | | Problematic wheezing, bronchitis, asthma, COPD, emphysema, shortness of breath?  Click here to add comment | | | | | | | | | Yes | | No | |
| 12. | | Any history of obstructive sleep apnoea? Click here to add comment | | | | | | | | | Yes | | No | |
| 13. | | Any significant infections of the lung e.g. tuberculosis? Click here to add comment | | | | | | | | | Yes | | No | |
| 14. | | Any other significant lung problems or respiratory conditions? Click here to add comment | | | | | | | | | Yes | | No | |
| **Endocrine / Renal** | | | | | | | | | | | | | | |
| 15. | | Do you have diabetes? Click here to add comment | | | | | | | | | Yes | | No | |
| 16. | | Any kidney disease or significant urinary or bladder problems? Click here to add comment | | | | | | | | | Yes | | No | |
| 17. | | Any thyroid disease or thyroid problem? Click here to add comment | | | | | | | | | Yes | | No | |
| 18. | | Any liver disease, jaundice or hepatitis? Click here to add comment | | | | | | | | | Yes | | No | |
| **Other Medical History** | | | | | | | | | | | | | | |
| 19. | | An organ transplantation? Click here to add comment | | | | | | | | | Yes | | No | |
| 20. | | Epilepsy or other significant neurological conditions (such as Parkinson’s disease)?  Click here to add comment | | | | | | | | | Yes | | No | |
| 21. | | A formal diagnosis of dementia or mental illness? Click here to add comment | | | | | | | | | Yes | | No | |
| 22. | | Any other medical condition for which you see a specialist /doctors / nurses? *Please state:*  Click here to add comment | | | | | | | | | Yes | | No | |
| **Allergies** | | | | | | | | | | | | | | |
| 23. | | Have you ever had an anaphylactic reaction? Click here to add comment | | | | | | | | | Yes | | No | |
| 24. | | Do you have any allergies? Please list any allergies you have, including medicines, metal, food, latex and plasters:  Click here to add comment | | | | | | | | | Yes | | No | |
| **Medications** | | | | | | | | | | | | | | |
| **Do you take?** | | | | | | | | | | | | | | |
| 25. | | More than 3 prescribed medicines? (Please list under question 30) Click here to add comment | | | | | | | | | Yes | | No | |
| 26. | | Oral diabetic medicines or insulin? Click here to add comment | | | | | | | | | Yes | | No | |
| 27. | | Blood thinning medicine e.g. warfarin, clopidogrel, ticagrelor, apixaban, rivaroxaban, heparin, aspirin? Click here to add comment | | | | | | | | | Yes | | No | |
| 28. | | Steroids or immunosuppressants? Click here to add comment | | | | | | | | | Yes | | No | |
| 29 | | Medicine for underactive or overactive thyroid? Click here to add comment | | | | | | | | | Yes | | No | |
| 30. | | Please list all current medications, if known:  Click here to add comment | | | | | | | | | | | | |
| **Functional capacity** | | | | | | | | | | | | | | |
| 31. | | Using the scale below, please tick by the number that most closely matches your exercise capability: | | | | | | | | | | | | |
|  | **1** | | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | | **10** | |  |
|  | **Walking around the house** | | **Domestic activities** | **Walk 200 yards without stopping** | **Gardening or golf (carrying clubs)** | **Cycling** | **Swimming** | **Easily climb 2 flights of stairs** | **Brisk swimming** | **Jogging** | | **Football / squash (competitive sports)** | |  |
|  | | | | | | | | | | | | | | |
| **Anaesthetic** | | | | | | | | | | | | | | |
| 32. | | Have you had any surgery / General anaesthetic in the past year? *Please list.*  Click here to add comment | | | | | | | | | | | | |
| 33. | | Have you or any of your blood relatives had any significant problems with an anaesthetic? Click here to add comment | | | | | | | | | Yes | | No | |
| 34. | | Do you have any restricted neck movement, restricted jaw movement, limited mouth opening, or have you had a previous tracheotomy? Click here to add comment | | | | | | | | | Yes | | No | |
| 35. | | Do you have significant heartburn, reflux disease or hiatus hernia?  Click here to add comment | | | | | | | | | Yes | | No | |
| 36. | | Have you ever been admitted to an Intensive Care Unit or previously been critically ill?  Click here to add comment | | | | | | | | | Yes | | No | |