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| --- | --- | --- |
| 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 wheelchairClick 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[ ]   |