Ulladulla Endoscopy and Medical Centre
111 Princes Highway, Ulladulla, NSW, 2539
Tel: 02 4455 5422 Fax: 02 4454 2263
admin@southmedical.com.au

(Affix Patient Label or handwrite)
Name:
DOB:
MRN:

# PRE-OPERATIVE QUESTIONNAIRE

Who is your Referring GP _____

| History | | YES | NO |
|---|---|---|---|
| 1. Do you have any allergies/adverse reactions to medicines, foods, chemicals, substances including Latex? (list the type and reaction) | | ☐ | ☐ |
| 2. What is your current weight and height? | Weight | Height | |
| 3. Do you have dentures, crowns, loose teeth, dental issues, etc? (please circle or list) | | ☐ | ☐ |
| 4. Do you have an Enduring Guardian/Substitute Decision Maker? If yes, give details. | | ☐ | ☐ |
| 5. Do you wish for a carer to be actively involved in your care? If yes, give details. | | ☐ | ☐ |
| 6. Do you have an Advance Care Directive? If yes, provide a copy. | | ☐ | ☐ |
| 7. Do you (or have you ever) smoke(d)? If yes, how many per day? ☐ ex-smoker | | ☐ | ☐ |
| 8. Do you drink alcohol? (how many / how often)? | | ☐ | ☐ |
| **Cardiovascular Risk** | | **YES** | **NO** |
| 9. Do you have any heart trouble, e.g.: chest pain, heart attacks, stents, AF, heart murmur, artificial heart valve, heart operations, pacemaker, or heart defects? (please circle or list) | | ☐ | ☐ |
| 10. Do you have high blood pressure or other blood pressure problems? | | ☐ | ☐ |
| **Breathing Issues** | | **YES** | **NO** |
| 11. Do you have breathing problems, e.g.: Asthma, Bronchitis, Emphysema, chronic lung disease, obstructive sleep apnoea, etc.? (please circle or list) | | ☐ | ☐ |
| 12. Do you get shortness of breath in normal activities (require rest breaks)? | | ☐ | ☐ |

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| Health Screening | YES | NO |
|---|---|---|
| 13. Do you have diabetes? If yes, what type? ☐ Insulin Dependent? ☐ Non-Insulin Dependent? | ☐ | ☐ |
| 14. Do you have anaemia? | ☐ | ☐ |
| 15. Do you have thyroid disease? | ☐ | ☐ |
| 16. Have you had a stroke or TIA or other neurological issues? | ☐ | ☐ |
| 17. Do you have epilepsy or Parkinson's or another seizure disorder? | ☐ | ☐ |
| 18. Do you have any Mental health issues, including suicidal thoughts, self-harming behaviours, anxiety, or any phobias? (please circle or list) | ☐ | ☐ |
| 19. Do you have any other serious illnesses or other health issues that may impact on your procedure? If yes, please provide details | ☐ | ☐ |
| 20. Do you have urinary or faecal incontinence? If yes, give details. | ☐ | ☐ |
| 21. Are you currently pregnant or breastfeeding? | ☐ | ☐ |
| **Previous Procedures** | **YES** | **NO** |
| 22. Have you had any previous surgeries? If yes, please provide details | ☐ | ☐ |
| 23. Have you or anyone in your family had anaesthetic problems? If yes, please provide details | ☐ | ☐ |
| 24. Endoscopy Patients only - Have you had any endoscopic procedures in the past, e.g. gastroscopy, colonoscopy? | ☐ | ☐ |
| 25. Endoscopy Patients only - Do you have any family history of bowel cancer or bowel polyps? | ☐ | ☐ |
| 26. Do you have any joint replacements/metal plates/pins/screws or implants/devices in your body? | ☐ | ☐ |
| **Comprehensive Care Plan** | **YES** | **NO** |
| 27. Do you need assistance with walking? If yes, please give details. | ☐ | ☐ |
| 28. Do you use a walking aid? If so, please bring your walking aid on the day of your procedure. | ☐ | ☐ |
| 29. Have you had a fall in the last 12 months? *Nursing Note: If Yes Alert Chief Nurse* ☐ *OR Recovery Nurse* ☐ | ☐ | ☐ |
| 30. Do you have a wound or pressure sore? If yes, give details | ☐ | ☐ |

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| *Nursing Note: If Yes Alert Surgeon* ☐ | | |
| 31. Have you ever had a blood clot before (DVT, PE)? If yes, give details<br>*Nursing Note: If Yes Alert Surgeon* ☐ | ☐ | ☐ |
| 32. Do you take warfarin or other blood thinners? If yes, give details<br>*Nursing Note: If Yes Alert Surgeon* ☐ | ☐ | ☐ |
| 33. Are you on any special diet and/or fluid restriction? If yes, give details<br>*Nursing Note: If Yes Alert Chief Nurse* ☐ *or Practice Manager* ☐ | ☐ | ☐ |
| 34. Have you lost weight recently without trying?<br>*Nursing Note: If Yes Alert Surgeon* ☐ | ☐ | ☐ |
| 35. Have you been eating poorly because of a decreased appetite?<br>*Nursing Note: If Yes Alert Surgeon* ☐ | ☐ | ☐ |
| 36. Do you have any problems with memory or dementia?<br>*Nursing Note: If Yes Alert Chief Nurse* ☐ OR *Practice Manager* ☐ | ☐ | ☐ |
| 37. Do you take medication that leaves you disorientated?<br>*Nursing Note: If Yes Alert Anaesthetist* ☐ | ☐ | ☐ |
| 38. Have you had delirium in hospital before?<br>*Nursing Note: If Yes Alert Anaesthetist* ☐ | ☐ | ☐ |
| 39. Do you have a reliable adult to stay with you for 24 hours after your operation? (NB: Failure to have a suitable adult to stay with you may result in cancellation of your procedure) | ☐ | ☐ |
| 40. Do you have any cultural needs or emotional needs? If yes, please give details | ☐ | ☐ |
| **Infection Risk** | **YES** | **NO** |
| 41. Do you currently have any type of infections (including COVID-19)? If yes, give details | ☐ | ☐ |
| 42. Have you been exposed to a person that is suffering an infectious disease in the past 2 weeks, i.e. chickenpox, measles, influenza, COVID-19? | ☐ | ☐ |
| 43. Have you ever been infected or colonised with a multi-resistant organism such as MRSA, VRE, CPE? | ☐ | ☐ |
| 44. Do you have a blood-borne virus such as HIV, Hepatitis C or Hepatitis B? | ☐ | ☐ |
| *Nursing Note: If Yes to 41-44, Alert Chief Nurse* ☐ | | |
| 45. Have had an overnight stay at an overseas hospital or residential care facility in the past 2 weeks? If yes, give details | ☐ | ☐ |
| **Medications** | **YES** | **NO** |

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| 46. Do you take Ozempic, Trulicity, Mounjaro or Wegovy injections? If Yes, circle correct one.<br><br>47. Do you take any regular medications? If yes, give details including dose and time taken | | |
| **Cataract Patients only - Screening Questions (49-52)** | **YES** | **NO** |
| 48. Do you have Creutzfeld-Jacob Disease (CJD)? | ☐ | ☐ |
| 49. Have you had two or more first degree relatives with CJD? | ☐ | ☐ |
| 50. Do you have a history of receiving human pituitary hormone for infertility or human growth hormone for short statue prior to 1986? | ☐ | ☐ |
| 51. Have you previously had surgery on the brain or spinal cord that included a dura mater graft prior to 1990? | ☐ | ☐ |

**Please fill out this pre-operative form and return it to Ulladulla Endoscopy & Medical Centre at least 2 weeks prior to your surgery.**

PLEASE SUPPLY YOUR ☐ ECG ☐ BLOOD TESTS ☐ HEALTH SUMMARY (From GP) ☐ MEDICATION LIST