York Teaching Hospital NHS
NHS Foundation Trust

Patient Label

Abdominal Wall Reconstruction - Health Screening Questionnaire

Date: ……..

We would be very grateful if you could complete the following questionnaire. The questionnaire is designed to give us an overview of your hernia and your general health which will help us in ensuring that you are optimally prepared for any surgery.

Personal Details	*Next of Kin*
Title : Dr Mr Mrs Ms Miss First Name: Surname: Date of birth: Preferred name: Address: Home Tel. No: Occupation: Work No: Mobile No: Email:	Name: Relationship: Address: Home Tel. No: Mobile No:

Audio/Video calling:

Are you able to access video calling on a laptop/PC/tablet or smartphone? Yes/No

If yes, do you have web browser google chrome or safari installed (on laptop or PC)? Yes/No

If no, and a telephone call is preferred, what is your preferred contact number?

GP name: GP surgery:	2nd Contact Name: Relationship to you: Tel. No:

Questionnaire:

Please tick Yes or No to the following questions and give further details you think may be helpful to us.

1. Your Hernia:	*Yes*	*No*	*Further details*
Does your hernia cause you problems?			
Is it painful?			
Do you ever have episodes of vomiting?			
Have you ever had an operation(s) on your hernia before?			
If 'yes' then please provide the following details for <u>each</u> of your previous hernia repairs:			

First Hernia Repair:	*Details*		
In what year was this surgery performed?			
Which hospital?			
Which surgeon?			
	Yes	*No*	*Further Details*
Was the surgery performed laparoscopically i.e. by keyhole surgery?			
Was a mesh used?			
Did the wound on your tummy breakdown after surgery?			
If 'yes' then how long did it take to finally heal?			

Second Hernia Repair:	*Details*		
In what year was this surgery performed?			
Which hospital?			
Which surgeon?			
	Yes	*No*	*Further Details*
Was the surgery performed laparoscopically i.e. by keyhole surgery?			
Was a mesh used?			
Did the wound on your tummy breakdown after surgery?			
If 'yes' then how long did it take to finally heal?			

Third Hernia Repair:	*Details*		
In what year was this surgery performed?			
Which hospital?			
Which surgeon?			
	Yes	*No*	*Further Details*
Was the surgery performed laparoscopically i.e. by keyhole surgery?			
Was a mesh used?			
Did the wound on your tummy breakdown after surgery?			
If 'yes' then how long did it take to finally heal?			

Fourth Hernia Repair:	*Details*		
In what year was this surgery performed?			
Which hospital?			
Which surgeon?			
	Yes	*No*	*Further Details*
Was the surgery performed laparoscopically i.e. by keyhole surgery?			
Was a mesh used?			

Did the wound on your tummy breakdown after surgery?			
If 'yes' then how long did it take to finally heal?			

Previous Operations & Anaesthetics		
Please give details of any operations that you have had? **Operation:**	**Hospital And Surgeon**	**Year**

	Yes	*No*		*Further details*
Have you ever had any problems with any previous anaesthetics?				If 'yes' please give details

Have any of your relatives had problems with anaesthetics?				If 'yes' please give details

4. Body Weight	*Yes*	*No*	*Further details*
What is your current weight?			
Do you feel that you are overweight?			
Have you tried to lose weight before?			
What is the lowest weight you have been as an adult?			
What is the highest weight you have been as an adult?			
Is your weight: ☐ going up ☐ staying the same ☐ going down ☐ unsure			

5. Activities / Exercise	*Yes*	*No*	*Further details*
Are you working at the moment?			
If 'yes' what kind of work do you do?			
How many times a week are you active for at least 30 minutes? e.g. walking, swimming, gardening?			
Do you think that you could walk a mile?			
Do you exercise regularly?			
Do you use a mobility aid (e.g. sticks, walking frame or wheelchair)?			

6. Diabetes	*Yes*	*No*	*Further details*
Do you have diabetes (diabetes mellitus)?			
If 'yes' are you treated with insulin or tablets?			

7. Immunity	*Yes*	*No*	*Further details*
Are you immunosuppressed?			
Do you take steroids?			
Have you ever been diagnosed as having any type of cancer?			

8. Smoking	*Yes*	*No*	*Further details*
Do you smoke now?			
If ‘yes’ would you like to give up?			
If ‘no’ did you used to smoke?			
If you used to smoke, when did you give up?			
How much did you used to smoke?			

9. Infection	*Yes*	*No*	*Further details*
Have you had any abdominal wound infections in the past?			
If ‘yes’ please give details			
Have you ever suffered a serious infection (e.g. MRSA, clostridium difficile?			
If ‘yes’ please give details			
Do you currently have a stoma?			
Do you currently have a bowel fistula?			
Do you currently have any open wounds / ulcers / blisters?			

10. Breathing Disorders	*Yes*	*No*	*Further details*
Do you have asthma, chronic obstructive airways disease or any other breathing disorder?			
Do you have asthma attacks more than once each month?			
Do you have sleep anoea?			

11. Heart Disease	*Yes*	*No*	*Further details*
Do you get chest pain or become breathless climbing two flights of stairs?			
Do you suffer with angina?			
Have you had a heart attack? If ‘yes’ please give year			
Are you currently being treated for an			

irregular heart beat?			
Have you ever been treated for heart failure?			
Have you ever been told that you have a heart murmur?			
Are you being treated for high blood pressure?			
Do you have a pacemaker or implanted defibrillator?			
Do you have any coronary stents?			

12. Hormone, renal, liver & bleeding disorders	Yes	No	Further details
Do you have thyroid disease?			
Have you ever been diagnosed with kidney disease?			
Have you ever been diagnosed as having hepatitis?			
Do you drink more than 1½ pints of beer or 3 shorts or ½ bottle of wine per day most days?			
Have you ever been diagnosed as having a blood clot in the leg (deep vein thrombosis) or in the lung (pulmonary embolism)?			
Have you or any close relative, been diagnosed with an inherited blood disorder such as sickle cell disease, clotting or bleeding disorder?			

13. Brain, nerve & musculoskeletal disorders	*Yes*	*No*	*Further details*
Have you been diagnosed as having epilepsy?			
Do you suffer from fainting or blackouts?			
Have you ever had a minor (TIA) or major stroke?			
Have you been diagnosed as having arthritis?			
Are you able to lie flat comfortably?			

14. Medications		
Are you currently taking any medications (prescribed, herbal, over the counter, recreational, vitamins or other)? Please give details (IN CAPITALS) or attach GP list		
Name of medicine	Dose	Freq.
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		

Please indicate if you are taking any of the following?	*Yes*	*No*	*Further details*
Anticoagulant tablets (for example aspirin, dipyridamole, warfarin, clopidogrel, prasugrel, dabigatran, apixiban)			

15. Allergies	*Yes*	*No*	*Further details*
Have you ever had a reaction to medicines or other substances (e.g. food/topical agents/latex/metal/other)? If 'yes' please give details.			

16. Other medical conditions	*Yes*	*No*	*Further details*
Is there any other medical condition or problem, not previously mentioned, that you feel we should know about?			

Clinical Photographs:

As part of the surgical planning process we normally take measurements of the hernia together with clinical photographs. Please read the enclosed information leaflet about your consent for clinical photographs and if you are in agreement please sign the enclosed consent form and bring this together with this health questionnaire to your consultation.

NB: This consent form will cover all future photographs with regards to the treatment of your abdominal wall hernia.

We look forward to seeing you on the day.