



Pre Surgery Enquiry Form - Gastric Surgery

Please complete this form carefully and honestly supplying as much of the information as you can. Your GP may be able to assist with this. Omitting relevant information may cause difficulties for you or the treating facility and may make it not possible for your treatment to proceed. (Please note if you are under the age of 18, this form must be completed & signed by a parent or guardian.)

Patient Details

Name **Date of Birth**

Address **Height**

..... **Weight**

.....

Tel home Tel work

Mobile Email

Next of Kin Details

Name **Relationship**

Address

.....

GP's Details

Name

Address

.....

..... **Tel**

Email **Fax**

Consultant/Specialist Details

Name

Address

.....

..... **Tel**

Email **Fax**

Please answer the following questions:

| | | |
|----------|---|-------|
| | Which Surgery is planned? (If it is for hip/knee/shoulder or ankle, please specify which side i.e. Right or left) | ..... |
| Yes / No | Are you allergic to any medication? If the answer is yes please list them. | ..... |
| Yes / No | Are you allergic to sticking plaster? | ..... |
| Yes / No | Are you allergic to any other products? If the answer is yes please list them. | ..... |
| Yes / No | Do you smoke? If so how many a day? | ..... |
| Yes / No | How many units alcohol do you drink per week? | ..... |
| Yes / No | Are you able to carry out normal physical activities? What are you unable to do? | ..... |
| Yes / No | Do you wear spectacles? | ..... |
| Yes / No | Do you wear contact lenses? | ..... |
| Yes / No | Do you wear dentures? | ..... |
| | When did you last visit the dentist? | ..... |
| Yes / No | Have you ever been treated for eye disease? If so which? | ..... |
| Yes / No | Do you snore at night? | ..... |
| Yes / No | Have you recently had a cold or flu? If so when? | ..... |
| Yes / No | Have you had any previous surgery? If so for what operation and when? | ..... |
| Yes / No | Have you ever suffered from any problems with anaesthesia such as Vomiting? | ..... |
| Yes / No | Or Pain? | ..... |
| Yes / No | Or Confusion? | ..... |

| | | |
|----------|---|-------|
| Yes / No | Or Respiratory difficulties? | _____ |
| Yes / No | Or Other? | _____ |
| Yes / No | Have you ever had a blood transfusion? What is your blood group? | _____ |
| Yes / No | Do you now suffer from any other medical problems? | _____ |
| Yes / No | Do you feel nauseous or unwell at the moment? | _____ |
| Yes / No | Do you take medicines? If yes, which and how much? | _____ |
| Yes / No | Do you bleed for long after a tooth extraction or injury? | _____ |
| Yes / No | Do you have any history of heart condition, constriction, pain in the chest, palpitations of the heart or heart attack? | _____ |
| Yes / No | Have you ever suffered from bronchitis, pneumonia, asthma or shortness of breath? | _____ |
| Yes / No | Are you diabetic? | _____ |
| Yes / No | Do you suffer from: Kidney disease? | _____ |
| Yes / No | Disease of the liver? | _____ |
| Yes / No | Thyroid disease? | _____ |
| Yes / No | Nerve disorders? | _____ |
| Yes / No | High blood pressure or any other disease not mentioned here? | _____ |
| Yes / No | Do you wish to mention anything special? | _____ |

MRSA Infection Control Policy

Secondary infection rates in Belgium are extremely low. DHI requests all patients to undergo **an oral smear test for MRSA** before surgery. This test will normally be carried out in the clinic or facility where your treatment will take place. They may also be obtained from your GP or physician.

What does the test involve? – The test is easy, painless and straightforward; a smear sample is taken from the nose and / or throat.

How often do you eat the following foods? Please tick the relevant box

| | Every day | Every week | Every month | Never |
|-------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Meat | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fish | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Eggs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Whole Wheat Bread | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Vegetables | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pasta | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Rice | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Potatoes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hot Spicy Foods | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pizza | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Burgers | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chips | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| crisps | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ice Cream | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chocolate | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cake | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fizzy Drinks | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cheese | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Coffee | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Alcohol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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Please print your name, sign & date below:

Date:/...../.....

Name:..... **Signature:**.....

