PATIENT CHOICE INTERNATIONAL

Pre-Surgery Enquiry Questionnaire

Patient's Personal Details:

Title: ……

First Name: ……

Surname: ……

Date of Birth: ……

Postal Address: ……

……

Post Code: ……

Email Address: ……

Telephone / Fax: ……

Mobile Phone: ……

Privacy statement:

Patient Choice International Ltd is committed to safeguarding the patient's privacy. Any medical information provided by patients will be kept strictly confidential and only be disclosed to others in connection with and for the purpose of treatment or treatment-connected administration.

Patient's Consent:

I give my consent to any relevant medical documentation including X-rays or other tests, as is deemed necessary, to be given out for the purpose of the following treatment.

Signature: …… Date: ……

*Tick boxes if you have the condition. Provide details in spaces. Use **BLACK INK**.*

What type of surgery would you like to have? Which side?

……

Have you been referred for this surgery by a consultant? Yes ☐ No ☐

Next of Kin Contact Details:

Title: ……

First Name: ……

Surname: ……

Postal Address: ……

……

Post Code: ……

Telephone/Mobile: ……

Patient's GP Contact Details:

Title: ……

First Name: ……

Surname: ……

Postal Address: ……

……

Post Code: ……

Email Address: ……

Telephone / Fax: ……

Patient's Consultant Contact Details:

Title: ……

First Name: ……

Surname: ……

Postal Address: ……

……

Post Code: ……

Email Address: ……

Telephone / Fax: ……

Patient's medical information:

Please note it is important that you answer all questions very carefully. You may wish to ask your GP to assist you with completing this part. Use ***BLACK INK***

What is your weight in kilos? ……

What is your height is cm? ……

What is your ethnic origin? ……

Do you have or have you ever had…

Heart Disease? Yes ☐ No ☐
If your answer is "Yes" please specify.

……

Angina / Chest pain? Yes ☐ No ☐

Irregular heart beat / Palpitations? Yes ☐ No ☐

High blood pressure? Yes ☐ No ☐
If your answer is "Yes" please specify how high.

……

Myocardial infarction? Yes ☐ No ☐
If your answer is "Yes" please give details.

……

Respiratory conditions? Yes ☐ No ☐
If your answer is "Yes" please specify which respiratory conditions.
eg. Asthma, Chronic Bronchitis, Other

…….

Kidney or Urinary Tract diseases? Yes ☐ No ☐
If your answer is "Yes" please specify which diseases.

……

Thyroid disease? Yes ☐ No ☐
If your answer is "Yes" please specify which thyroid disease.

eg. Hyperthyroidism, Hypothyroidism

……

Diabetes Mellitus? Yes ☐ No ☐
If your answer is "Yes" please specify which type.

……

Diabetic foot? Yes ☐ No ☐

Liver disease? Yes ☐ No ☐
If your answer is "Yes" please specify which liver disease.
eg. Jaundice, Hepatitis, Cirrhosis

……

Skin diseases? Yes ☐ No ☐
If your answer is "Yes" please specify which skin diseases.

……

Tuberculosis? Yes ☐ No ☐
If your answer is "Yes" please say when and what treatment you received.

……

Osteo-arthritis? Yes ☐ No ☐

Rheumatoid arthritis? Yes ☐ No ☐

Sleep disorders? Yes ☐ No ☐
If your answer is "Yes" please specify which sleep disorders.

……

Neurological conditions? Yes ☐ No ☐
If your answer is "Yes" please specify which neurological conditions.
e.g. Stroke, Epilepsy, Blackouts/Fainting, Transient Ischaemic Attack, other

……

Contagious Diseases? Yes ☐ No ☐
If your answer is "Yes" please specify which contagious diseases.

……

Parasitic infections? Yes ☐ No ☐
If your answer is "Yes" please specify which parasitic infections.

……

Injuries? Yes ☐ No ☐
If your answer is "Yes" please specify what injuries.

……

Varicose veins? Yes ☐ No ☐

Deep Vein Thrombosis? Yes ☐ No ☐

Surgical operations? Yes ☐ No ☐
If your answer is "Yes" please specify what operations you have undergone.

Operation	Date	Complications

Blood transfusion? Yes ☐ No ☐
What is your blood group?

……

Do you…

take any medications including steroids? Yes ☐ No ☐
If your answer is "Yes" please list all your medications.

Name of medication	Dose	Frequency

take contraceptive pills? Yes ☐ No ☐

smoke? Yes ☐ No ☐
If you smoke say how many cigarettes a day?

drink alcohol? Yes ☐ No ☐
If you drink alcohol please say how many units per week?

(Pint of beer/lager = 2 units; Glass of wine = 1 unit; Spirit measure = 1unit)

……

snore at night? Yes ☐ No ☐

wear spectacles? Yes ☐ No ☐

wear contact lenses? Yes ☐ No ☐

wear dentures? Yes ☐ No ☐

When did you last have your dental treatment?

……

Are you allergic to …

any medications? Yes ☐ No ☐
If your answer is "Yes" please list those medications and state symptoms.

……

……

any foods? Yes ☐ No ☐
If your answer is "Yes" please list those foods.

……

elastoplast, latex or iodine? Yes ☐ No ☐
If your answer is "Yes" please specify.

……

any other substances? Yes ☐ No ☐
If your answer is "Yes" please list them.

……

Have you ever had a bad reaction to anaesthesia? Yes ☐ No ☐
If your answer is "Yes" please give detail. This could involve symptoms such as vomiting, breathing difficulties, pain or confusion.

……

Has any family member had a bad reaction to anaesthesia? Yes ☐ No ☐
If your answer is "Yes" please give detail.

……

Are you able to manage normal everyday activities? Yes ☐ No ☐
If your answer is "No" please describe your restrictions.

……

……

How far can you walk? What sort of orthopaedic aid equipment do you use? (eg. frame, crutches, wheelchair)

……

Have you recently had a cold or flu? Yes ☐ No ☐
If your answer is "Yes" please say when.

……

Are you pregnant? Yes ☐ No ☐
If your answer is "Yes" please say which month.

……

Important Information

Patient Choice International Ltd cannot accept any responsibility for the outcome of any medical treatment. Patient Choice International Ltd employees neither practice medicine nor give medical or legal advice either directly or indirectly.

Patient Choice International Ltd is not responsible for any travel arrangements.

Only when the service provider is satisfied the proposed treatment is applicable for the patient will therapeutic intervention be undertaken. The clinical judgements made will be to ensure the best possible treatment of the patient and to avoid inconvenience or reduce the risk of complications. Patient Choice International is not responsible for any refusal by clinicians to treat requested conditions if they deem them inappropriate to the service available.

Prior to the treatment, the hospital will hold a preliminary consultation with the patient, which will form the basis of an informed consent consisting of a) details of the nature and severity of the disease for which treatment is being offered, b) advice on the treatment options available, c) effects of no treatment, d) specific risks of the proposed treatment and e) risks of surgery in general.

The medical treatment prices include transport from and to the airport in Poland, consultation, diagnostic examinations, agreed treatment, hospitalisation. The treatment price does not include the cost of flights. The treatment price sometimes does not include the cost of prostheses or additional equipment. The treatment price dose not include the cost of additional consultations, treatment, hospitalisation or medication, which may be needed after being revealed during the patient stay or treatment. Should a need for such additional treatment arise the cost will be discussed with the patient.

The full payment must be made directly to the chosen hospital before the treatment.

I understand that failure to provide full information may result in the necessity of postponing or refusing my treatment.

Print Name: .....

Signature: …… Date: ……..

Once you have completed, signed and dated the Pre-Surgery Questionnaire please send it along with your cheque to:

Patient Choice International Ltd
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London, N1 7GU