	NHS York and Scarborough Teaching Hospitals 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	Name:
First Name:	Relationship:
Surname:	Address:
Date of birth:	
Preferred name:	
Address:	
Home Tel. No:	Home Tel. No:
Occupation:	Mobile No:
Work No:	
Mobile No:	
Email:	

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?			
If ‘no’ what stops you from walking e.g. pain (where), breathless, etc. and how far can you walk?			
Do you exercise regularly?			
If ‘yes’ how often and describe the exercise.			
Have you thought about exercising as a way to improve your health and fitness?			
How much time do you spend, during a week, sitting or lying i.e. not active?			
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?			
Was this treated with chemotherapy or radiotherapy or both?			

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 (COPD) or any other breathing disorder?			

How many hospital admissions have you had in the last 12 months?			
Have you ever been admitted to the intensive care unit because of your breathing?			
If 'yes' please give details e.g. did you need a tracheostomy			
Do you use inhalers and/or nebulisers at home?			
Do you use home oxygen?			
Do you have sleep apnoea?			
Do you use a CPAP machine at night?			
If 'yes' how long you have used CPAP for, and how many hours a night do you use it for?			

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			
Have you had angioplasty (a balloon to open up a blocked artery) or heart bypass surgery?			
If "yes" please give details			
Do you have coronary stents?			
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 an implanted defibrillator?			

12. Hormone, renal, liver & bleeding disorders	Yes	No	Further details
Do you have thyroid disease?			
Have you ever been diagnosed with kidney disease?			
If 'yes' please give details of any treatment you are receiving for your kidney disease? e.g. dialysis			

Have you ever been diagnosed as having hepatitis?			
Do you drink more than 1½ pints of beer or 3 shots 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?			
How frequent are your seizures?			
Do you suffer from fainting or blackouts?			
Have you ever had a minor (TIA) or major stroke?			
Do you have any other neurological disease such as multiple sclerosis?			
If 'yes' please give details			
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, apixaban)			

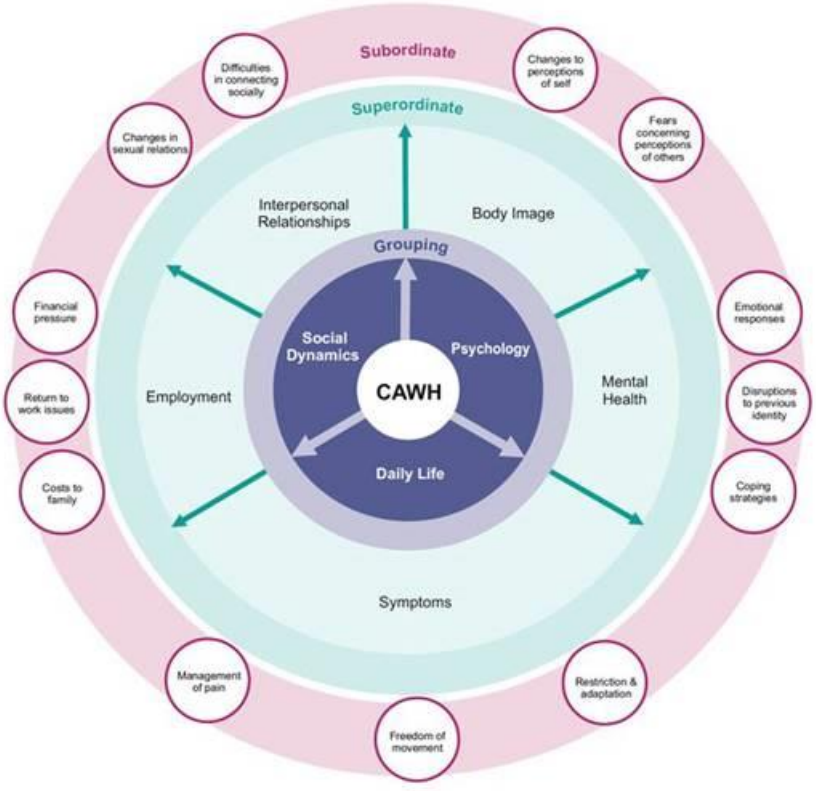
15. Allergies	*Yes*	*No*	*Further details*
Have you ever had a reaction to medicines or other substances (e.g. food/topical agents/latex/metal/other)? If 'yes' please give details.			

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?			

17. Quality of Life

We would like you to tell us how the abdominal wall hernia affects your quality of life. Our previous patients have told us the following areas they have been affected in. You may find that some or all of these areas are applicable to you. If so, please tell us:



Body Image: (Changes to perceptions of self; fears concerning perceptions of others)

Mental Health: (Emotional responses; disruptions to previous identity; coping strategies)

Symptoms: (Restrictions and adaptations; freedom of movement; management of pain)

Employment: (Costs to family; return to work issues; financial pressure)

Interpersonal relationships: (Changes in sexual relations; difficulties in connecting socially)

17. Shared decision making

Please take time to answer the following questions, thinking about your answers and what you would like to achieve from the consultation.

1. What matters to you

2. What you hope will happen as a result of the consultation

3. What questions you would like to ask at the consultation

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.