Pre-consultation patient questionnaire.

The information you provide is important to your treatment, so it is crucial that you try and answer the following questions as accurately as possible. Answering this questionnaire, will also give us more time at the consultation to concentrate on what you have come for.

Thank you
Barbara Jemec

CURRENT PROBLEM

Please describe the problem you have come to try and resolve today:

Have you had treatment for this before? yes/no if yes, when?
By whom?

What is your aim with the treatment you are seeking?

How did you hear about me? GP / other doctor / self referral/ other

ALLERGIES

Are you allergic to any medication? please list:

Are you allergic to Shellfish? yes/no
Are you allergic to eggs? yes/no
Anything else?

Please circle all the symptoms the medication(s) you are allergic to, have provoked:

Skin rash	Swelling
Hives	Shortness of breath
Itching	Runny nose
Fever	Wheezing
Itchy, watery eyes	

Have you ever had an anaphylactic shock? yes/no

If yes, to what medication?

What happened exactly?

MEDICATION

Do you take any medication?
If yes, please list the medication, the dose and frequency you take it and who prescribed it for you

medication	dose	frequency	prescriber

Do you take any blood thinning medication such as Aspirin / Clopidrogel or Warfarin?
Do you take any steroids?
Do you take any immunosuppressants?
Please list above

PAST MEDICAL HISTORY

Do you suffer from (please circle any which apply) :

high blood pressure	skin problems e.g. eczema
angina	thyroid problems
heart disease	diabetes
kidney problems	dizziness/ passing out
epilepsy	

have you ever had a heart attack yes/no if yes, when?
have you ever had a stroke yes/no if yes, when?

please add anything I might have left out:

PREVIOUS OPERATIONS

Have you had any previous operations?

Type of operation, e.g. hernia	Year	Hospital	Type of anaesthesia e.g. local, spinal, block or general	Did you suffer any complications? yes/no If so which?	Did the operation help your initial problem? e.g. yes, no, somewhat

Have you had Botox/ fillers and if so when was the last time?

Have you ever suffered from hypertrophic scarring/ keloid scarring/ stretched scarring?
yes/no, please circle which applies to you

PREVIOUS ANAESTHETICS

Have you or your relatives experienced any problems with anaesthetics in the past?

SOCIAL HISTORY

What do you do for a living (I need to try to determine how an operation might impact on your ability to work or your daily activities)?

Do you have any physical hobbies, such as skiing, basketball etc?

Do you play a musical instrument? yes/ no
If so which?

Are you right or left handed (please circle)? left / right / ambidextrous

Do you smoke? yes/no If yes, how many cigarettes/cigars/roll-ups/pipes a day?

Do you vape? yes/no

Do you use Nicotine replacements? gum / patches / nasal sprays

If you do no longer smoke, but have smoked in the past, how long ago did you gave up?

Do you drink alcohol? yes/no if yes, how many units a week?

I attest to the above information being correct at the time of signing, and that I have filled this form out to the best of my abilities.

I agree/don't agree to my General Practitioner and other clinicians involved in my care to be informed of my treatment under Miss Jemec.

I agree/don't agree to Miss Jemec taking pre-, intra-and post-operative photographs, which will be anonymised and used for my medical records.

I do/do not mind if my photographs are used for informing other patients about the same procedure I have had done. The photographs will not be publicly displayed.

Name (please write legibly):

Address:

Phone number and Email contact:

GP name and address:

Signature date