Mr. Shailesh Vadodaria MB BS MS MCh FRCS(Inter-Plastic)
Consultant Aesthetic & Reconstructive Surgeon GMC NO: 438 64 21
Tel: 02070 784 378
Email: info@macsclinic.co.uk
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ANAESTHETIC PRE-OPERATIVE ASSESSMENT

made by Dr (Mrs) Vadodaria for Mr Vadodaria's patients

SURNAME: **[PatientLastname]**	ASSESSMENT DATE: [TodayShort]
FIRST NAME: **[PatientFirstname]**	SURGERY DATE:
DOB: [PatientDoBLong]	[PatientMobile] [PatientHomeTel]
Address:	
ETHNIC ORIGIN Caucasian/Afro-Caribbean/Asian/Other	
GP details-	

Please, answer questions by putting "x" mark on pages 1-4 for Medical Assessment and move to Psychological Assessment form (page 5-12).

You are strictly prohibited to change the document except to answer the question.

PREVIOUS HISTORY / OPERATIONS

ANAESTHETIC HISTORY	YES	NO
Previous General Anaesthesia		
Previous Epidural /Spinal Anaesthesia		
Problem with Anaesthetics patient / family		
History of nausea / vomiting post op		
History of travel sickness		
Do you have backache?		
CURRENT MEDICATIONS (follow guidance with following drugs) discuss with Mr Vadodaria at your consultation		
OC Pill (Consider stopping)		

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HRT (Consider stopping)		
Blood pressure tablets- ACE inhibitors (Consider stopping)		
Warfarin/Clopidogrel/Aspirin		
Insulin / Oral hypoglycaemic		
Steroids (In last 6 months)		

Give details as necessary

Medication Details (Specify dose and frequency)

ALLERGY (State allergen, eggs & describe effect on patient, gluten)	YES	NO
Medications		
Anaesthetics		
Latex-itching/swelling following the wear of household gloves or after eating tropical fruits- melons, avocados, bananas?		
Iodine/ Contrast		
Food eg. Eggs		
Other eg. Elastoplast		
Have you any disabilities?		
Wear any body piercing?		
Do you intend to travel with 3 months of your surgery?		
Females only, could you be pregnant or intend to be?		
Date of last menstral period		
Females only, are you breast feeding? If until recently when did you stop?		

CARDIOVASCULAR	**YES**	**NO**
Hypertension		
Myocardial infarction- date, details		
Angina		
Exercise induced / rest pain / stable		

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Palpitation/ Arrhythmia		
Rheumatic fever		
Murmur / prosthetic heart valve		
Pacemaker – last checked		
Peripheral vascular disease		

Breathless	**YES**	**NO**
At rest/ washing/ dressing		
Doing housework/ gardening		
On the flat/ 1 flight of stairs/ on hills		
Is patient stopped by leg pain or joint pain?		
Are laying flat / 1 pillow a problem?		
Shortness of breath on lying down without pillows?		
Ankle swelling		
Sudden death to young family member		

RESPIRATORY	**YES**	**NO**
Recent chest infection/ Productive cough		
Asthma/ Wheeze – stable / worse, last attack		
Ever hospitalized / oral steroids		
Chronic bronchitis/ emphysema		
History of TB		
Sleep Apnoea (sleepiness/ snoring)		

GASTRO INTESTINAL	**YES**	**NO**
Reflux/ hiatus hernia/ Indigestion		
Peptic ulceration		
Jaundice		
Liver disease		
Urinary/ kidney disease		
Renal impairment / failure		

BLOOD	**YES**	**NO**
Anaemia/Thalassemia		

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White cells / Platelet disorder		
Bruise / Bleed easily		
Previous DVT/PE – date, details		
Family history		
Sickle cell anaemia/ trait		
Problems with accepting blood transfusion		
Problem with previous transfusion		

MISCELLANEOUS	**YES**	**NO**
Diabetes mellitus – diet, oral, insulin		
Have you had aa documented blood test for diabetes		
Recent changes in health		
Thyroid disease		
Epilepsy / fits – last fit		
Stoke / blackouts – residual weakness		
Muscle disease / weakness		
Rheumatoid arthritis		
Psychiatric disorder/ depression / anxiety/panic attacks		
Any cancellation of appointments due to panic		

SOCIAL HISTORY	YES	NO
Do you smoke? If yes how may? If stopped when? How many did you smoke a day?		
Do you drink? (1 unit= 1 single spirit, 1 glass of wine, ½ pint of beer)		
Recreational drug use		
Female- pregnant if so inform surgeon – last LMP*		
Previous MRSA		

Patient Vaccination Status		**Name of Vaccine**
Date of first vaccine if applicable		
Date of second vaccine if applicable		

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If no vaccines yet given, is there a date scheduled for one?		

Please go to Psychological Assessment form (page 6-12).

***If between now and the operation you do get pregnant, please do inform us. is not advisable to have surgery done in case of pregnancy. It will be your responsibility if you do go ahead with the operation in case you do get pregnant.**

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PSYCHOLOGICAL ASSESSMENT

Today's date: [TodayShort]

Name: [PatientName]

DOB: [PatientDoBShort]

Ethnicity:

Occupation:

Sex:

Features for which you are considering surgery:

1. Are you currently under the care of a mental health professional, or receiving treatment for your psychological needs?

Yes No

1. Have you ever been under the care of a mental health professional, or received treatment for your psychological needs?

Yes No

2. Have you ever been advised to take medication for anxiety, depression or any other emotional problems?

Yes No

3. Are you such a perfectionist that it interferes with your work?

Yes No

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4. Have you ever perceived your body or parts of your body as ugly, disgusting or shameful?

Yes No

5. Have you ever had cosmetic surgery, then felt dissatisfied with the result, or felt that you needed further surgery to put it right?

Yes No

With regard to the feature for which you are considering surgery:

How noticeable is it now?

Least *Most*

1 2 3 4 5 6 7 8 9 10

How much do you worry about it now?

Least *Most*

1 2 3 4 5 6 7 8 9 10

How self conscious of your appearance do you feel now?

Least *Most*

1 2 3 4 5 6 7 8 9 10

To what extent do you avoid activities because of your appearance

Your work life

Least *Most*

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1 2 3 4 5 6 7 8 9 10

Your social life

Least *Most*

1 2 3 4 5 6 7 8 9 10

Your sexual and intimate life

Least *Most*

1 2 3 4 5 6 7 8 9 10

To what extent do you feel the need to check your appearance in the mirror?

Least *Most*

1 2 3 4 5 6 7 8 9 10

Regarding self-confidence, how confident do you feel in relation to the following:

At work

Least *Most*

1 2 3 4 5 6 7 8 9 10

Social life

Least *Most*

1 2 3 4 5 6 7 8 9 10

Sexual and intimate life

Least *Most*

1 2 3 4 5 6 7 8 9 10

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How many times a day do you check your appearance? ……

On a typical day, how long do you spend looking in the mirror? …….

In what ways do you expect your life to be different after surgery?

……
……
……

Declaration by patient-

I confirm that the above information about my health is true and complete and accept responsibility for any repercussions that may occur if I omit or manipulate any facts.

Thank you for completing this form.

Please return your completed form to a member of the clinic team.

Signature: …… **Signature:** ……

Date: …… **Date:** ……

Patient Name: [PatientName] **Consultant: Mr. Shailesh Vadodaria**

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FOR OFFICE USE ONLY

To be booked in MACS/CCH/Harley/Welbeck MPU/Main Theatres

Score DVT risk- Fill a separate form and after that -

Unsuitable for MACS Clinic- if any of the following is ticked Yes
Please tick as appropriate-

Miscellaneous	Serious uncontrolled Medical Conditions	Social	Bleeding Abnormalities
Surgery (most commonly, abdominal, pelvic and orthopaedic)	Pregnancy, postpartum	Patients having hearing difficulties or patients who don't understand the languages spoken by the clinicians and nursing staff in the procedure room.	Activated protein C resistance
Major trauma, burns	Myocardial infarction		Factor V Leiden
Prolonged travel	Congestive heart failure		Prothrombin gene mutation G20210A
Paralysis (including anesthesia for >30 min)	Stroke		Hyperhomocysteinemia
Varicose veins	Obesity		Anticardiolipin antibodies
Less than 18 years of age	Inflammatory bowel disease		Lupus anticoagulant
History/High risk for Deep vein thrombosis /VTE	Nephrotic syndrome		Elevated factor VIII level
Cardiac arrhythmias or any positive cardiac issues	History of VTE		Protein C deficiency
Patients taking Warfarin and INR more than 1.5.	Serious uncontrolled		Protein S deficiency

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	Medical Conditions		
Patients having known history of allergy to local anaesthetics, botulinum toxin or absorbable dermal filler.	Pregnancy, postpartum		Dysfibrinogenemia
Patients with difficult airways/potentially intubation.	Dementia		Dysplasminogenemia
Indwelling venous catheters	Learning disability		Antithrombin deficiency
	Severe psychological disorder		

FOR NURSE / DOCTOR TO FILL-

Height=

Weight=

BMI=

Pulse=

Blood Pressure=

AIRWAY ASSESSMENT-(in the clinic) Mouth opening (uvula soft palate seen)	YES	NO
Neck extension	YES	NO
Bite upper lip (with teeth)	YES	NO

INVESTIGATIONS & MANAGEMENT

BASIC INVESTIGATIONS	**Ordered**	**Results reviewed**

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FBC		
U& E		
Sickle cell if Afro Caribbean or Asian		
If BMI>30, Fasting and Postprandial blood sugar, if abnormal then HBA1C If>60years, or cardiac history= ECG		

TO BE FILLED BY in-charge Doctor-

1. **SNORING- Y/N**
2. **TIREDNESS-Y/N**
3. **OBSERVED BY PARTNER THAT PATIENT STOPPED BREATHING IN SLEEP Y/N**
4. **PRESSURE HIGH Y/N**
5. **BMI>35 Y/N**
6. **AGE>50 Y/N**
7. **NECH CIRCUMFERENCE>40 CM Y/N**
8. **GENDER MALE Y/N**

SCORE>3 INFORM ANAESTHETIST

INTENDED PROCEDURE:
Patient's preferred anaesthetic: GA/regional/local/local with sedation