

HAND AND UPPER LIMB SURGEON

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PRE-OPERATIVE QUESTIONNAIRE

Today's Date:/...../.....

Surname First name

Date of Birth / /

Please list your medications:
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Are you diabetic?

- Yes
- No

If yes, do you take Insulin (Humalog, Lantus, Novolog, Levemir)?

- Yes
- No

Are you taking any of the following diabetic medications? (if yes, need to cease 3 days prior)

- Dapagliflozin (Forxiga)
- Empagliflozin (Jardiance)
- Canagliflozin (Invokana or Xigduo Jardiamet)

Please list any other diabetic medications.....
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Are you taking any of the following blood thinning medications?

- Aspirin (Astrix, Cartia)
- Ticagrelor (Brilinta)
- Warfarin (Coumadin, Marevan, Jantoven, Dindevan)
- Fondaparinux (Arixtra)
- Heparin (Fragmin, Innohep, and Lovenox)
- Apixaban (Eliquis)
- Dabigatran (Pradaxa)
- Edoxaban (Savaysa)
- Rivaroxaban (Xarelto)
- Clexane (Lovenox)
- Clopidogrel (Iscover, Plavix)
- Dipyridamole (Asasantin)

If yes, why are you taking this medication?

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If a Cardiologist or other specialist is looking after you, please provide their details.....

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Are you taking Fish oil supplements (Krill oil, Turmeric)? **(if yes, need to cease 5 days prior)**

- Yes
- No

Please list any allergies you have:

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Do you have a Latex allergy?

- Yes
- No

If yes, adverse reaction:.....

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Have you ever had a DVT or PE (blood clot)?

- Yes
- No

If yes, please write details:

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Have you ever had a stroke/TIA?

- Yes
- No

If yes, please write details:

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Have you ever had a blood clotting disorder such as von Willebrand or Factor V Leiden?

- Yes
- No

If yes, please write details:

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Have you ever had any of the following:

- Pacemaker/stents/valve replacement or any other cardiac history
- Respiratory issues or long-term steroid use
- Organ transplant
- Spinal injuries
- Neurological condition
- Any other significant medical condition (if yes, please provide details).....

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If you ticked any of the above, please provide details (including the details of any Cardiologist or Specialist that treated you for that condition):

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Have you ever had any issues with anaesthetic in the past?

- Yes
- No

If yes, please write details:

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Any other information we should be aware of:

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Are you vaccinated for Covid-19?

- Yes Single Double Booster
- No

Have you tested positive for Covid-19?

- Yes If yes, the date you tested positive _____
- No