Supplement 1: Patient information and self-assessment questionnaire

Dear Patient

The Anaesthesia Network for South Africa (ANSA) is an initiative of the SA Society of Anaesthesiologists (SASA). The objective of ANSA is to gather information and to use this information to improve anaesthesia care in South Africa, both in the private and public sector. ANSA is working to achieve this objective through research-driven pilot projects. More information on ANSA can be found on www.ansa.org.za.

You may be eligible for inclusion in one of the ANSA research projects. You are eligible for the study as described on the following page if you are 18 years or older, and *not* undergoing emergency surgery, a heart operation or procedure to your heart, or a caesarian section.

Your participation in this project is voluntary. You can refuse to participate or stop at any time without giving any reason. Once the answers to the questions have been captured, you cannot recall your consent. We will not be able to trace your information. Therefore, you will also not be identified as a participant in any publication that comes from the ANSA project.

Note: The implication of answering the questions is that you consent to the inclusion of this anonymous information in the ANSA database. Thus any information derived may be used (only as combined data) by persons authorised by SASA. No patient names will be included and personal identifiers will be hidden.

The ANSA database is used to track care received and the outcomes of healthcare, and for practice/institutions to compare themselves against national averages. The data will assist in establishing what is happening in terms of patient care. The database is secure, and mechanisms are in place to ensure that there is no unauthorised access to any information stored.

Please note that answering these questions does not imply consent to anaesthesia.

Dear Patient

It is important for the doctors and nurses who will take care of you before, during and after your operation to know how healthy or sick you are before the operation. The questionnaire that follows is similar to questions asked by people that will be involved with your care. This questionnaire is part of a doctoral study in Anaesthesiology in the Department of Anaesthesiology, University of Pretoria. You are invited to participate voluntarily in this research project on "The development of a model to predict outcome after elective non-cardiac surgery using a preoperative self-assessment questionnaire in a South African private hospital population." The Research Ethics Committee of the University of Pretoria, Faculty of Health Sciences, telephone numbers 012 3541677 / 012 3541330 granted written approval for this study.

Before answering the 'screening' questions you received information on the Anaesthesia Network for South Africa (ANSA). The answers to the next questions will be stored in the ANSA database. Before you agree to fill in the questionnaire you should fully understand what is involved. If you do not understand the information or have any other questions, please contact the researcher at +27 83 680 3839, or +27 12 373 1054. You should not agree to take part unless you are completely happy about what is expected of you.

To complete the questionnaire may take about 10 - 20 minutes. This paper questionnaire will be collected in a sealed box and it will be kept in a safe place to ensure confidentiality. You may ask a family member or friend to assist you in completing the questionnaire.

The questions will help to determine your health status. You may have to answer such questions again for any of the people involved in your care. The result of the research project will be used to improve the care of all patients going for an operation in South Africa. Please answer the questions as carefully and completely as you can. Your participation in this study is voluntary. You can refuse to participate or stop at any time without giving any reason. Once you have given the questionnaire back to us, you cannot recall your consent. We will not be able to trace your information. Therefore, you will also not be identifiable in any publication that comes from this study.

Note: By completing the questionnaire you give consent that we may use your health information without using your name. Please note that completion of this questionnaire does not imply consent to surgery or anaesthesia.

Instructions: Please tick YES or NO to the questions where indicated. In some cases, should you answer YES, this leads to more questions. Please make sure that these questions are also answered. Deposit the completed questionnaire in the sealed box provided, to ensure confidentiality.

Date of form completion	2	0	Y	Y	M	M	D	D
This form is being completed by the patient					**Yes**		**No**	
If not, does the patient have the mental ability to complete the form?					**Yes**		**No**	
The form is being completed:								
In the doctor's rooms		At hospital administration		In the ward				

Personal Information																		
ID or Passport number																		

Date of birth	Y	Y	Y	Y	M	M	D	D	Gender	**Male**	**Female**
Race	**Black**			**White**			**Asian**				**Mixed race**
Please provide contact number (We will only contact you when there is data missing in your survey)											
Information on operation											
Have you been operated for the same problem during the past month?										**Yes**	**No**
What is your weight?	kg			What is your height?						cm	
Choose ONE of the following to describe your health in general: (Check ✓)											
You consider yourself a healthy person											
You have an on-going (chronic) condition/illness that affect your daily life only mildly; that is, you can continue with your daily life as previously											
You have an on-going (chronic) condition/illness that affect your daily life severely, that is, the disease does not allow you to continue with you daily life as previously											
You have an on-going (chronic) condition/illness that is a constant threat to life, so severe that you must stay in bed to survive											
Is the disease(s) mentioned above the reason for having the operation (if applicable)?										**Yes**	**No**
Are you active or fit enough to:											
Get out of bed or a chair yourself?										**Yes**	**No**
Dress or bathe yourself?										**Yes**	**No**
Make your own meals?										**Yes**	**No**
Do your own shopping or sweep the floor?										**Yes**	**No**
Paint a room or mow the lawn?										**Yes**	**No**
Climb two flights of stairs without stopping?										**Yes**	**No**
Choose ONE of the following reasons for being less active (if applicable): (Check ✓)											
Joint, bone or back problems											
Difficult breathing											
Pain, pressure or discomfort in your chest, neck or arm											
Pain or cramps in your legs											
Your health:											

Do you have high blood pressure?	**Yes**	**No**	**If yes, since when?**	Year	Month
If yes, do you take medication for high blood pressure regularly?				**Yes**	**No**
Have you ever been told that you have a problem with the blood supply to your heart?				**Yes**	**No**
			If yes, when?	Year	Month
Have you ever had a heart attack?	**Yes**	**No**	**If yes, when?**	Year	Month
Have you ever received a stent in the blood supply to your heart?				**Yes**	**No**
			If yes, when?	Year	Month
Have you ever had a bypass or surgery to the blood supply to your heart?				**Yes**	**No**
			If yes, when?	Year	Month
Do you take a small daily dose of aspirin?				**Yes**	**No**
Have you ever been told that you have a weak heart?				**Yes**	**No**
			If yes, when?	Year	Month
Do you have an abnormal heart valve?				**Yes**	**No**
Have you received surgery to a heart valve?				**Yes**	**No**
Have you had rheumatic fever?				**Yes**	**No**
Have you noticed your heart beating very fast, very slow or irregularly, on a frequent basis?				**Yes**	**No**
If yes, have you felt dizzy or blacked out when this happens?				**Yes**	**No**
Have you been diagnosed with abnormal heart rate or rhythm?				**Yes**	**No**
Do you take medication for abnormal heart rate or rhythm?				**Yes**	**No**
Do you have an implanted pacemaker or defibrillator?				**Yes**	**No**
Have you had blackouts or fainting without warning?				**Yes**	**No**
Have you felt dizzy or blacked out while exercising?				**Yes**	**No**
Do you have any weakness or numbness in your arms or legs?				**Yes**	**No**
Do you wake up at night because of difficult breathing?				**Yes**	**No**
Do you get short of breath when lying flat on your back?				**Yes**	**No**
Do your ankles or legs swell?				**Yes**	**No**
Do you take a diuretic ('water tablet') every day?				**Yes**	**No**
When going up the stairs between two floors, do you have to rest in between?				**Yes**	**No**

Do you wake up coughing at night?				**Yes**	**No**
Do you have 'bad circulation' in your hands or feet?				**Yes**	**No**
Have you been diagnosed with disease of the large blood vessels such as the aorta?				**Yes**	**No**
Have you had surgery to the large blood vessels?				**Yes**	**No**
Have you ever had to see a doctor for lung problems of any kind?				**Yes**	**No**
If yes, did the lung problems affect you during the last month?				**Yes**	**No**
Have you ever been admitted to hospital for any lung problems?				**Yes**	**No**
Are you using oxygen at home?				**Yes**	**No**
Have you been smoking cigarettes in the past year?				**Yes**	**No**
Did you smoke before but stopped?				**Yes**	**No**
If yes, how many years have you been smoking/did you smoke?					
How many cigarettes per day do you smoke/did you smoke?					
Have you had a cold or 'flu' in the past 2 weeks?				**Yes**	**No**
Did you have a fever or chills in the past 2 weeks?				**Yes**	**No**
Have you tested positive for HIV?	**Yes**	**No**	If yes, when?	Year	Month
Have you ever been treated for tuberculosis?				**Yes**	**No**
Have you ever been told you have cancer?				**Yes**	**No**
Have you ever had an operation for cancer?				**Yes**	**No**
Have you ever received medication or radiation for cancer?				**Yes**	**No**
Are you currently receiving medication or radiation for cancer?				**Yes**	**No**
Have you been told that the cancer is not under control, or has spread?				**Yes**	**No**
Have you ever had any kidney problems?				**Yes**	**No**
Do you currently have kidney problems?				**Yes**	**No**
Have you ever received dialysis?				**Yes**	**No**
Are you currently receiving dialysis?				**Yes**	**No**
Have you ever had jaundice (yellow skin or eyes) as an adult?				**Yes**	**No**
Have you been told that you have a liver disease?				**Yes**	**No**
Do you have symptoms of the liver disease at the moment?				**Yes**	**No**

Do you have scarring (hardening) of the liver or liver damage?				**Yes**	**No**
Do you have high cholesterol?	**Yes**	**No**	**If yes, since when?**	Year	Month
Do you use medication for high cholesterol?	**Yes**	**No**	**If yes, since when?**	Year	Month
Are you "apple-shaped" (more fat around the waist than the hips)?				**Yes**	**No**
Do you have diabetes (high blood sugar)?	**Yes**	**No**	**If yes, since when?**	Year	Month
Do you use insulin for the diabetes?	**Yes**	**No**	**If yes, since when?**	Year	Month
Have you ever been diagnosed with an underactive thyroid gland?				**Yes**	**No**
If yes, are you taking medication?				**Yes**	**No**
Have you ever been diagnosed with an overactive thyroid gland?				**Yes**	**No**
If yes, are you taking medication?				**Yes**	**No**
Did you eat less than usual or changed your eating habits in the past two weeks?				**Yes**	**No**
Have you lost weight or decreased your dress size in the past 6 months, without dieting?				**Yes**	**No**
Are you pregnant?				**Yes**	**No**
For women: When was your last normal menstruation?	Y	Y	Y	Y	M	M	D	D
Have you had a blood clot in the deep veins or in your lung previously?				**Yes**	**No**
For women: Do you take female hormones, the pill, or do you receive any contraceptive injections?				**Yes**	**No**
Do you have a disease that causes your blood to clot abnormally fast?				**Yes**	**No**
Have you been diagnosed with inflammatory bowel disease?				**Yes**	**No**
Do you use any medication to make the blood thin?				**Yes**	**No**
Do you have a disease that prevents your blood from clotting?				**Yes**	**No**
Have you suffered from short-lived weakness in your arms or legs, or short-lived blindness?				**Yes**	**No**
Have you had a stroke?				**Yes**	**No**
Have you been feeling sad or depressed much of the time?				**Yes**	**No**
Do you take medication for depression?				**Yes**	**No**
Are you in constant pain for any reason?				**Yes**	**No**
If yes, are you taking pain medication or receiving treatment?				**Yes**	**No**
Do you get heartburn?				**Yes**	**No**
Do you have any difficulty to swallow?				**Yes**	**No**

Do you have any narrowing in your mouth, throat, or air pipe that makes your breathing difficult or noisy?					**Yes**	**No**
Have you been told that you snore?					**Yes**	**No**
Do you often feel tired, fatigued, or sleepy during daytime?					**Yes**	**No**
Has anyone seen you stop breathing while you are sleeping?					**Yes**	**No**
Has a doctor diagnosed you with sleep apnoea?	**Yes**	**No**	If yes, when?		Year	Month
How often did you have a drink with alcohol in the past year?						
Never	**Monthly or less**	**2-4 times a month**	**2-3 times a week**	**4 or more times a week**		
How many drinks did you have on a typical day when you were drinking in the past year?						
1 or 2	**3 or 4**	**5 or 6**	**7 to 9**	**10 or more**		
How often did you have 6 or more drinks on one occasion in the past year?						
Never	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**		
Has any food or medicine caused you to itch, breathe difficult or develop swelling?					**Yes**	**No**
If yes, what caused the reaction?						
Do you use recreational or street drugs?					**Yes**	**No**
Do you use anabolic steroids or testosterone?					**Yes**	**No**
Do you use herbal medication or natural remedies?					**Yes**	**No**
Previous operations						
Have you had an abnormal reaction to an anaesthetic?					**Yes**	**No**
Are you aware of any difficulty to place a tube into your windpipe to help you with breathing during a previous operation?					**Yes**	**No**
Have you ever had nausea and/or vomiting after surgery?					**Yes**	**No**
Have you ever had prolonged confusion after surgery?					**Yes**	**No**
Did you have an unexpected blood transfusion after surgery?					**Yes**	**No**
Were you ever admitted to ICU unexpectedly after surgery?					**Yes**	**No**
Were you ever in hospital for longer than expected after an operation?					**Yes**	**No**
Do you have a family history of any of the following: **(Please note that should a term be completely strange to you, it is highly unlikely that you have a family member that was diagnosed with the problem)**						

Someone died because of anaesthesia-related problems	**Yes**	**No**
Someone stayed in hospital for longer because of anaesthesia-related problems	**Yes**	**No**
Malignant Hyperthermia (an inherited disease triggered by anaesthesia)	**Yes**	**No**
Scoline Apnoea (an inherited problem triggered by a muscle relaxant)	**Yes**	**No**
Porphyria (an inherited disease that may be triggered by some medication)	**Yes**	**No**

Final questions:

How confident are you in filling out medical forms by yourself?

Extremely confident	**Quite confident**	**Somewhat confident**	**A little bit confident**	**Not at all confident**

Are you satisfied with the information you have received about what to do, and what to expect before, during and after the operation, and after discharge?	**Yes**	**No**	**Unsure**

Thank you for completing this questionnaire. Please ensure that it is deposited in the sealed box provided. We wish you all the best for the planned procedure.