



Health Questionnaire

Patient Details

(Please Circle)

Mr/Mrs/Ms/Miss/Master/Dr - First name: Surname:

Parent/Guardian if 16 or under: First name: Surname:

Address: Postcode:

Contact Phone No's: Home: Mobile: Work:

Date of Birth: Height: Weight:

Email:

GP: Phone:

Operation Details

Anaesthetist: Date of surgery:

Surgeon: Hospital:

Operation:

Workcover or Third Party Details

Employer Name:

Address:

Postcode:

Telephone: Claim No:

Workcover Insurance Company:

Health Insurance Details

Medicare No: □□□□ □□□□□□ Ref: □

Do you have hospital cover: Yes/No

Health Fund:

Membership No:

Concession Card/DVA No:

Full Pension Part Pension Seniors Card

Please Give Details of any Previous Anaesthetic Problems

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Allergies and Sensitivities – List all Drugs, Foods and Describe the Reaction

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Medications	Dose	Frequency	Medications	Dose	Frequency

Patients Name:

Health Questionnaire Continued

Have you had any operations in the past? Yes No If yes please detail as follows :

Date	Operation	Surgeon	Hospital

Have any of your relatives had problems with anaesthesia? Yes No

Have you taken Aspirin, Warfarin, Clopidogrel or other blood thinners in the last week? Yes No

Do you have or have you ever suffered from:

Heart problems?
eg. Palpitations, fainting, funny turns
or heart murmurs etc.? Yes No

High blood pressure? Yes No

Breathing or respiratory difficulties? Yes No

Obstructive sleep apnoea? Yes No

Diabetes? Yes No

Kidney disease? Yes No

Neck or jaw stiffness? Yes No

A Gastric Band or Bypass Surgery? Yes No

Epilepsy, seizures or convulsions? Yes No

Psychiatric illness? Yes No

Contact with infectious disease?
(eg Hepatitis, HIV or AIDS) Yes No

Previous blood clots or pulmonary
embolism? Yes No

Unusual or excessive bleeding or
bruising? Yes No

Heartburn, gastric reflux or
hiatus hernia? Yes No

Dental problems? Yes No

– Dentures? Yes No

– Caps or Crowns? Yes No

– Loose or broken teeth? Yes No

Do you smoke? Yes No

How many per day?

Do you drink alcohol? Yes No

How many per day?

Females – is there any possibility
you are pregnant? Yes No

If you have answered yes to any of the questions, please provide further details:

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Any additional information / medical conditions or health issues your doctor should be advised of?

Please attach extra sheets if needed:

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