specialist anaesthetic services

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Health Questionnaire

Patient Details

(Please Circle)
Mr/Mrs/Ms/Miss/Master/Dr - First name: ..... Surname: .....

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

(Please Circle) (Please Circle)
Gender: M/F/Other - ..... He/She/They/Other - .....

Address: ..... Postcode: .....

Primary Contact No's: Mobile: ..... *used to remind of appointments and cost

Date of Birth: ..... Height: ..... Weight: .....

Email: ..... *used to send information about procedure and costs etc.

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

If your surgery is less than 1 week away, then take this questionnaire with you to the hospital.

Please Turn Over and Complete

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

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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At all times we are required to ensure your details are treated with the utmost confidentiality.
Your records are very important to us and we will take all steps to ensure they remain confidential.

I ..... give consent to contact me via the contact details provided regarding information on my procedure, account or other related matters.

Signature ..... Date .....