specialist anaesthetic services

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Health Questionnaire

Patient Details

(Please Circle)

Mr/Mrs/Ms/Miss/Master - 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: .....

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 No: .....

☐ Full Pension ☐ Part Pension ☐ Seniors Card

Please Give Details of any Previous Anaesthetic Problems

.....

.....

.....

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

.....

.....

.....

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:

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

Please attach extra sheets if needed: .....