HEALTH QUESTIONNAIRE

pulse anaesthetics

PATIENT TO COMPLETE

PATIENT DETAILS

Name: _____ DOB: _____

Address: _____ Postcode: _____

Phone: _____ Mobile: _____ Email: _____

GP Name: _____ Phone: _____

GP Address: _____

HEALTH INSURANCE DETAILS

Do you have hospital cover: Yes / No Full / Extras

Health Fund: _____

Membership No: _____

Medicare No: _____

Concession Card No: _____

☐ Full Pension ☐ Part Pension ☐ Seniors Card

WORKCOVER OR THIRD PARTY DETAILS

Workcover Insurance Company: _____

_____

Case Manager: _____

_____

Telephone: _____ Claim 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

Previous blood clots or pulmonary embolism? ☐ Yes ☐ No

Unusual or excessive bleeding or bruising? ☐ Yes ☐ No

Heartburn, gastric reflux or hiatus hernia? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No How many per day? ____

Do you drink alcohol? ☐ Yes ☐ No How many per day? ____

Females – Are you are pregnant? ☐ Yes ☐ No

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

Dentures, Caps or Crowns? ☐ Yes ☐ No

PLEASE LIST ANY OPERATIONS YOU HAVE HAD IN THE PAST

_____

_____

_____

HAVE YOU OR YOUR RELATIVES HAD PROBLEMS WITH ANAESTHETICS?

_____

HAVE YOU TAKEN ANY BLOOD THINNING MEDICATION IN THE LAST WEEK? ☐ Yes ☐ No

eg. Aspirin, Clopidogrel, Warfarin, Apixaban (Eliquis), Rivaroxaban (Xarelto)

_____

PLEASE LIST ANY ADDITIONAL INFORMATION / MEDICAL CONDITIONS OR HEALTH ISSUES

_____

_____

_____

Please turn over and complete remaining section...

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PATIENT TO COMPLETE

Patient Name: _____ Height: _____ cm Weight: _____ kg BMI: _____

Anaesthetist: _____ Surgeon: _____ Hospital: _____

Operation: _____ Date of Surgery: _____

MEDICATIONS (Please list all drugs and doses)

MEDICATIONS (Please list all drugs and doses)

ALLERGIES AND SENSITIVITIES (Please List)

DOCTOR TO COMPLETE

PRE ANAESTHETIC ASSESSMENT

CLINICAL HISTORY

EXAMINATION FINDINGS

HR BP SpO_2 RR

AIRWAY: TMD cm

Neck Movement Mallampati score:

Difficult airway anticipated? Yes | No

TEETH: Caps | Crowns | Dentures

Previous history of PONV ☐

Increased risk of regurgitation / aspiration ☐

Does the patient have sleep apnoea ☐

High analgesic requirements anticipated ☐

ANAESTHETIC PLAN AND INVESTIGATIONS

Fasting instructions ☐

Medications discussed ☐

Risks discussed ☐

ASA Classification: 1 2 3 4 5

ANAESTHETIST SIGNATURE: