HEALTH QUESTIONNAIRE

pulse anaesthetics

PATIENT TO COMPLETE

PATIENT DETAILS

Name: _____ DOB: _____

Address: _____ Postcode: _____

Phone: _____ Mobile: _____ Email: _____

Anaesthetist: _____ Surgeon: _____ Operation: _____

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

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 ☐

ASA Classification: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

ANAESTHETIC PLAN

Fasting instructions ☐

Medications discussed ☐

Risks discussed ☐

ANAESTHETIST SIGNATURE:

STAFF ACTION LIST (Please tick requests)

Book ☐ HDU ☐ ICU bed ☐

Book echocardiogram ☐

Exercise stress test ☐

Book pulmonary function testing ☐

Follow up blood investigation results ☐

Location: .....

PRE ANAESTHETIC ASSESSMENT