

Please complete the following questions concerning your general health.

This will help us assess your fitness for Anaesthesia and Surgery.

NAME: _____ Medicare NO.: _____
Private Fund: _____

HEIGHT: _____

DOB _____ WEIGHT: _____

ADMITTING TIME: _____

Please Circle Either Yes or No

- | | | |
|--|-----|----|
| 1. HAVE YOU EVER HAD AN ANAESTHETIC BEFORE? | YES | NO |
| 2. DID THIS AFFECT YOU IN ANYWAY? | YES | NO |
| 3. IS THERE ANY HISTORY OF PROBLEMS WITH ANAESTHETICS? | YES | NO |
| 4. ARE YOU CURRENTLY HAVING TREATMENT FROM YOUR G.P? | YES | NO |
| 5. HAVE YOU HAD ANY OF THE PROBLEMS LISTED BELOW? | | |

COMMENTS

- | | | |
|--------------------------------|-----------|----------|
| A) HEART TROUBLE/ MURMER? | YES _____ | NO _____ |
| B) CHEST PAIN? | YES _____ | NO _____ |
| C) DIABETES? | YES _____ | NO _____ |
| D) HIGH BLOOD PRESSURE? | YES _____ | NO _____ |
| E) STROKE? | YES _____ | NO _____ |
| F) FITS/EPILEPSY/BLACKOUTS? | YES _____ | NO _____ |
| G) BRUISING/BLEEDING? | YES _____ | NO _____ |
| H) THROMBOSIS/BLOOD CLOTS? | YES _____ | NO _____ |
| I) BREATHING PROBLEMS? | YES _____ | NO _____ |
| J) ASTHMA? | YES _____ | NO _____ |
| K) PERSISTANT COUGH? | YES _____ | NO _____ |
| L) RECENT COLD? | YES _____ | NO _____ |
| M) ANAEMIA? | YES _____ | NO _____ |
| N) JAUNDICE/HEPATITIS? | YES _____ | NO _____ |
| O) KIDNEY DISEASE? | YES _____ | NO _____ |
| P) CORTISONE TREATMENT? | YES _____ | NO _____ |
| Q) INDIGESTION/HEARTBURN? | YES _____ | NO _____ |
| R) NECK/SPINAL PROBLEMS? | YES _____ | NO _____ |
| S) DO YOU HAVE A GASTRIC BAND? | YES _____ | NO _____ |

PLEASE TURN OVER

6. DO YOU SMOKE?_____ IF SO HOW MANY?_____

7. DO YOU DRINK ALCOHOL?_____ IF SO HOW MUCH?_____

8. HAVE YOU EVER HAD AN INFECTIOUS DISEASE? YES / NO

9. ARE YOU ALLERGIC TO ANY DRUGS/ MEDICINE/ ELASTOPLAST? YES / NO ?

IF SO, PLEASE SPECIFY _____

10. ARE YOU TAKING ANY MEDICATION NOW OR IN THE LAST MONTH?

YES/NO? PLEASE SPECIFY.

11. HAVE YOU ANY OF THE FOLLOWING? (PLEASE CIRCLE)

LOOSE TEETH CAPS/CROWNS BRIDGES ON TEETH DENTURES

12. FEMALES: ARE YOU PREGNANT? YES / NO

ARE YOU TAKING AN ORAL CONTRACEPTIVE? YES / NO

13. DO YOU HAVE VON WILLEBRANDS YES/NO

14. WOULD YOU LIKE DR CLAPIN TO CONTACT YOU YES/ NO