EPSOM ANAESTHESIA

Patient Questionnaire Form

Complete this form if you will be undergoing a procedure and consent to Anaesthesia. This form is required to fulfill the criteria for surgery.
All information is sought to minimize your risk and will be retained by the Anaesthetist as part of your confidential clinical record.
Please answer all questions as accurately as possible

General Details

Family Name:		First Name(s):			
Address:					
Day Contact No:		After Hrs Contact No:		Email:(used for all written communication)	
Date of Birth:		NHI No:		Are you a New Zealand Resident:	☐ Yes ☐ No ☐ Male ☐ Female

General Practitioner Details

Doctor's Name:		Practice Name:		Contact Nos:	

Your Planned Procedure

Proposed Surgery:			
Surgeon:		Anaesthetist:	
Date & Place		ACC Claim? ☐ Yes - Claim No: _____ ☐ No - ☐ Insurance Company:_____ Membership/ Claim No: _____ ☐ Partial Cover ☐ Full Cover ☐ Other: _____ ☐ Self-Pay	

Your Weight _____ ***kg*** ***Your Height*** _____ ***metres***

Health Questionnaire – Do you suffer from or have you suffered from, the following

	Yes	No		Yes	No		Yes	No
High Blood pressure	☐	☐	Emphysema	☐	☐	Stroke	☐	☐
Previous Heart Attack	☐	☐	Persistent Cough	☐	☐	Blackouts/fainting	☐	☐
Heart Murmur	☐	☐	Shortness of breath	☐	☐	Medication for long term pain	☐	☐
Palpitations or unusual beating	☐	☐	Obstruction sleep apnoea	☐	☐	Recreational drugs	☐	☐
Artificial heart valve or pacemaker	☐	☐	Anaemia	☐	☐	Steroids (e.g prednisone)	☐	☐
Chest pains/tightness or angina	☐	☐	Bleeding or excessive bruising	☐	☐	Joint or metal implant	☐	☐
How often_____			Blood clots in legs/lungs	☐	☐	Arthritis	☐	☐
When did it last occur_____			Blood transfusion	☐	☐	Do you smoke or Vape?	☐	☐
Hiatus hernia/heartburn/indigestion	☐	☐	Hepatitis/jaundice	☐	☐	How many daily? _____		
Previous rheumatic fever	☐	☐	Risk of exposure to hepatitis	☐	☐	if you stopped, when _____		
Asthma	☐	☐	Kidney problems	☐	☐	Do you drink alcohol?	☐	☐
Tuberculosis	☐	☐	Diabetes	☐	☐	if yes, how much _____		

If you answered 'Yes' to any of the above, please give further details below e.g. if you have ticked chest pains, please note the name of your Cardiologist

Please list previous surgery, including year and hospital if known:

Surgery	*Date*	*Hospital*

Name of patient:

Have you or any of your family had problems with an anaesthetic? ☐Yes ☐ No
if yes please outline

What medications (including Herbal) and / or drugs are you taking?

Medication and Dose	Time taken

Please note: Do not stop any medication that your specialist has prescribed without consulting your anaesthetist.

Do you have allergies to medication, tablets, plasters, food, LATEX and other substance Yes No, please list

Substance	Type of reaction

Are you under any regular medical specialists care e.g. Cardiologist, Oncologist
If yes, please specify:

Have you tested positive for Covid? If yes, please note the date when, you were positive.

_____

Do you have a problem opening your mouth? (E.g. previous jaw problems) ☐ Yes ☐ No

Note all physical activities you regularly participate including walking, flights of stairs (one, two):

_____

Do you feel restricted by: ☐ Shortness of breath, ☐chest pain, ☐ joint pain, any other please specify:

_____

Are there any significant major illnesses, to your knowledge, among your blood relatives?
e.g, muscular dystrophy, malignant hyperthermia ☐Yes ☐No
if yes please list

Do you suffer from any other condition, not covered elsewhere, that you feel we should know about ☐Yes ☐ No
If yes please outline

Do you have any concerns or questions about your anaesthetic☐ yes ☐no if yes please outline

Women only. *Are you or could you be pregnant .* ☐Yes ☐No

The above details have been completed by ☐Patient ☐ Parent ☐ Caregiver ☐other (Specify)

Print Name: _____ *Sign Here:* _____ *Date:* _____

Please note:

- If you have urgent queries, please contact your anaesthetist at his/her room or your surgeon.
- If your anaesthetist believes there are significant risks identified in this qu*estionnaire, he/she may contact you to make an appointment before surgery and may gather your medical information.*
- *If you have any reservations for your anaesthetist in obtaining your medical information, please tick this box* ☐
- ***Please carry all your medications with you to the hospital / facility***

Please complete this questionnaire ASAP and submit this to your surgeon

EPSOM ANAESTHESIA

P O Box 99054 Newmarket, Auckland, 1149
Tel: 09-5245135 FX: 09-5249389
Email: reception@epsomanaesthesia.co.nz