

Full name: _____

DOB: _____ Phone: _____

Email: _____

Procedure: _____

Height: (cm) * _____ Weight: (kg) * _____ BMI Calculator: _____

Do you have the following: Please circle **Do you have the following:** Please circle

Diabetes: Type 1/Type 2 Yes No Prosthesis? Yes No

if yes, diabetic management/medications (list) if yes, type (pacemaker, stents, joints)

High or low blood pressure? Yes No Smoker/have you ever smoked? Yes No

if yes, any medication if yes, how many per day

Heart issues? Yes No Use recreational drugs? Yes No

if yes, details (e.g. valve replacement, angina, heart attack) Drink alcohol? Yes No

if yes, quantify

Are you on blood thinners? Yes No Visual impairment? Yes No

Short breath after 2 flights of stairs? Yes No Glasses/contact lenses? Yes No

Wake up feeling short of breath? Yes No Hearing aids? Yes No

Do you have ankle swelling? Yes No Contact with or history of Covid-19? Yes No

Sleep apnoea? Yes No if yes, date of infection ____/____/____

Use home oxygen/CPAP machine? Yes No Travel overseas within last 14 days? Yes No

Asthma/emphysema/bronchitis? Yes No Hospitalisation overseas in last 12 months? Yes No

Autism/Anxiety/Behavioural concerns? Yes No Infectious disease? (HIV/Hepatitis/TB) Yes No

if yes, details History of multi resistant bacteria? (MRSA) Yes No

Pregnancy/breast feeding? Yes No

Epilepsy/Fits/Seizures? Yes No Cancer? Yes No

MS/Motor Neurone Disease? Yes No if yes, type and location

Dementia? Yes No

Stroke/TIA? Yes No Chemotherapy/radiotherapy? Yes No

Migraines/Motion sickness? Yes No if yes, type and location

Bleeding/clotting? Yes No

Blood disorders? Yes No Do you have someone to take you home? Yes No

Cough, cold, sore throat in last 14 days? Yes No Will someone be with you 24hrs after general anaesthetic? Yes No

Indigestion/reflux/heartburn? Yes No

Bowel bleeding/constipation/diarrhoea? Yes No

Bladder problems? Yes No

Kidney Disease? Yes No

Physical disability/mobility issues? Yes No

Speech or swallowing problem? Yes No

Limited jaw movement? Yes No

Neck or back problems? Yes No

Arthritis? Yes No

if yes, location/type

Thyroid issues? Yes No

Please list previous anaesthetic history:

Please list allergies and reactions to drugs or food:

Completed by (name): _____ Signature: _____ Date: __/__/__