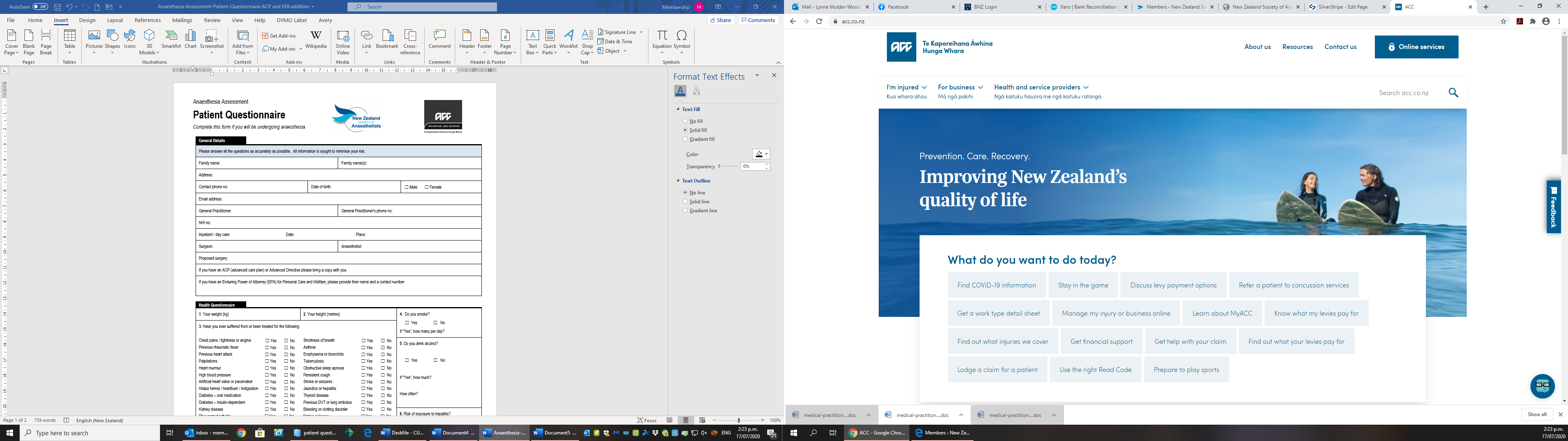
Anaesthesia Assessment





**Patient Questionnaire**

*Complete this form if you will be undergoing anaesthesia.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **General Details** |  | | | |
| Please answer all the questions as accurately as possible. All information is sought to minimise your risk. | | | | |
| Family name: | | | Family name(s): | |
| Address: | | | | |
| Contact phone no: | | Date of birth: | | Male  Female |
| Email address: | | | | |
| General Practitioner: | | | General Practitioner’s phone no: | |
| NHI no: | | | | |
| Inpatient / day care: Date: Place: | | | | |
| Surgeon: | | | Anaesthetist: | |
| Proposed surgery: | | | | |
| If you have an ACP (advanced care plan) or Advanced Directive please bring a copy with you. | | | | |
| If you have an Enduring Power of Attorney (EPA) for Personal Care and Welfare, please provide their name and a contact number | | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Health Questionnaire** |  | | | | | | |
| **1**. Your weight (kg) | | | | **2**. Your height (metres) | | | | | **4**. Do you smoke?  Yes  No  If “Yes”, how many per day? | |
| **3**. Have you ever suffered from or been treated for the following: | | | | | | | | |
| Chest pains / tightness or angina  Previous rheumatic fever  Previous heart attack  Palpitations  Heart murmur  High blood pressure  Artificial heart valve or pacemaker  Hiatus hernia / heartburn / indigestion  Diabetes – oral medication  Diabetes – insulin-dependent  Kidney disease  Rheumatoid arthritis  Neurological Condition | | Yes  Yes  Yes  Yes  Yes  Yes  Yes  Yes  Yes  Yes  Yes  ☐ Yes  Yes | No  No  No  No  No  No  No  No  No  No  No  No  No | Shortness of breath  Asthma  Emphysema or bronchitis  Tuberculosis  Obstructive sleep apnoea  Persistent cough  Stroke or seizures  Jaundice or hepatitis  Thyroid disease  Previous DVT or lung embolus  Bleeding or clotting disorder  Motion sickness  MRSA/ESBL | Yes  Yes  Yes  Yes  Yes  Yes  Yes  Yes  Yes  Yes  Yes  ☐ Yes  No | | No  No  No  No  No  No  No  No  No  No  No  No  No | | **5**. Do you drink alcohol?  Yes  No  If “Yes”, how much?  How often? | |
| **6**. Risk of exposure to hepatitis?  Yes  No | |
| **7**. If you answered “Yes” to any of the above, please give further details: | | | | | | | | | | |
| **8**. Please list or attach previous surgery, including year and hospital if known: | | | | | | | | | | |
| **Surgery** | | | | | | **Date** | | | | **Hospital** |
|  | | | | | |  | | | |  |
|  | | | | | |  | | | |  |

|  |
| --- |
| Name of patient: |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **9**. What medications (including herbal) and / or drugs are you taking? | | | |  | |  |
| **Medication** | | | | **Dose** | | **Time Taken** |
|  | | | |  | |  |
| **`** | | | |  | |  |
|  | | | |  | |  |
| **10**. Do you have problems opening your mouth? (e.g. previous jaw problems)  Yes  No | | | | | | |
| **11**. Have you been told of any difficulties during your anaesthetic?  Yes  No | | | | | | |
| **12**. Do you have dentures, partial plate, capped or loose teeth?  Yes  No | | | | | | |
| **13**. What physical activities do you take part in on a regular basis? (Tick those that apply)  Walking  Gym work  Tennis  Golf  Other (specify): | | | | | | |
| **14**. How many flights of stairs can you climb without getting out of breath?  One flight  Two flights  Three flights or more | | | | | | |
| **15**. my activity is restricted by:  Shortness of breath  Chest pain  Joint pain | | | | | | |
| **16**. Do you have allergies to medications, tablets, plaster, food, LATEX or any other substance?  Yes  No If “Yes”, please list. | | | | | | |
| **Substance** | | | **Type of Reaction** | | | |
|  | | |  | | | |
| **17**. Are there any major illnesses, to your knowledge, among your blood relatives?  Yes  No If “Yes”, please list.  e.g. diabetes, muscular dystrophy, malignant hyperthermia | | | | | | |
|  | | |  | | | |
|  | | |  | | | |
| **18**. Do you or any of your family had problems with an anaesthetic?  Yes  No If “Yes”, please outline. | | | | | | |
|  | | | | | | |
| **19**. Do you suffer from any other condition, not covered elsewhere, that you feel we should know about?  Yes  No If “Yes”, please outline. | | | | | | |
|  | | | | | | |
| **20**. Do you have any concerns or questions about your anaesthetic?  Yes  No If “Yes”, please outline. | | | | | | |
|  | | | | | | |
| **21**. Do you wish to see your anaesthetist before coming to hospital?  Yes  No | | | | | | |
| **22**. **Women only** – Are you or could you be pregnant?  Yes  No | | | | | | |
| **Signature** |  | | | | | |
| **I give permission for my/my child’s medical records and investigation results to be accessed for the purpose of assisting in my anaesthetic**  Yes  No | | | | | | |
| The above details have been completed by:  patient  guardian  relative  other (specify): | | | | | | |
| Signature: | | Date: | | | Print name: | |
| If you have urgent queries, please contact your anaesthetist at his/her rooms or your surgeon.  If your anaesthetist believes there are significant risks identified in this questionnaire, he/she may contact you to make an appointment before surgery.  **Please bring all your medications with you to hospital.** | | | | | **Please send/give this completed questionnaire to:** | |