ANAESTHESIA ASSESSMENT

Patient Questionnaire

Complete this form if you will be undergoing anaesthesia.

New Zealand Society of Anaesthetists (Incorporated)

PREVENTION. CARE. RECOVERY.
Te Kaporeihana Āwhina Hunga Whara

GENERAL DETAILS

Please read the anaesthetic booklet and answer all questions as accurately as possible.
All information is sought to minimise your risk, and will be retained as part of your confidential clinical record.

Family name:	First name(s):	
Address:		
Contact phone no.	Date of birth:	☐ Male ☐ Female
General Practitioner:	General Practitioner's phone no.	
NHI no.	Community Services Card no.	Expiry date:
Is this an ACC claim? ☒ Yes ☐ No	If "Yes", please provide ACC no.	
Inpatient / Day care:	Date:	Place:
Surgeon: Mr Ivan Spika	Anaesthetist: Dr Vera Spika	
Proposed surgery:		

HEALTH QUESTIONNAIRE

1. Your weight (kg):

2. Your height (metres):

3. Do you suffer from, or have you ever suffered from, the following:

Chest pains / tightness or angina	☐ Yes	☐ No	Shortness of breath	☐ Yes	☐ No
Previous rheumatic fever	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Previous heart attack	☐ Yes	☐ No	Emphysema or bronchitis	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No	Obstructive sleep apnoea	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No	Persistent cough	☐ Yes	☐ No
Artificial heart valve or pacemaker	☐ Yes	☐ No	Stroke or seizures	☐ Yes	☐ No
Hiatus hernia / heartburn / indigestion	☐ Yes	☐ No	Jaundice or hepatitis	☐ Yes	☐ No
Diabetes – oral medication	☐ Yes	☐ No	Thyroid disease	☐ Yes	☐ No
Diabetes – insulin-dependent	☐ Yes	☐ No	Previous DVT or lung embolus	☐ Yes	☐ No
Kidney disease	☐ Yes	☐ No	Bleeding or clotting disorder	☐ Yes	☐ No
Rheumatoid arthritis	☐ Yes	☐ No	Motion sickness	☐ Yes	☐ No

4. Do you smoke?

☐ Yes ☐ No

If "Yes", how many per day?

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 below:

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

SURGERY	DATE	HOSPITAL

Name of the 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, plasters, 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. Have 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

20. **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 THIS COMPLETED QUESTIONNAIRE TO:

Mr Ivan Spika

PO Box 74446 Market Road AUCKLAND 1051