



ANAESTHETIC QUESTIONNAIRE

Office use only.

SURNAME.....GIVEN NAME.....

ID NUMBER.....SEX.....

DATE OF BIRTH.....PHONE.....

Patient Name..... DOB..... Weight..... Height.....

Surgeon..... Anaesthetist.....

	Please Circle
1. Have you or a family member had a problem with anaesthetic?	Yes No
2. Are you allergic or sensitive to anything at all? If YES please list on reverse side.	Yes No
3. Do you take any blood thinning medication? (<i>Please do not cease medication unless advised by your surgeon</i>)	Yes No
4. Do you have Diabetes ? If Yes are you Insulin dependent? YES / NO if yes - Pump YES / NO Non-Insulin dependent YES / NO if yes - Tablets / Diet	Yes No
5. Have you had or are you being treated for High blood pressure ?	Yes No
6. Have you had or do you have Asthma ?	Yes No
7. Have you had Hepatitis /liver disease / jaundice/ kidney disease?	Yes No
8. Have you had or are you being treated for heart problems including Chest pain / angina / pacemaker / palpitations stents / valve replacement / shortness of breath after exertion?	Yes No
9. Do you suffer from Epilepsy / fits / blackouts ?	Yes No
10. Have you had a Stroke ? If yes, what year?.....	Yes No
11. Have you ever had persistent anaemia / bleeding or clotting disorder?	Yes No
<i>Please indicate if you have any of the following by circling:</i>	
12. hearing aid prosthesis joint replacements dentures bridge	Yes No
13. Do you have glaucoma?	Yes No
14. Have you had surgery in the last 6 months? If yes, what type of surgery?	Yes No
15. Are you pregnant?	Yes No
16. Do you suffer from Gastric Reflux (Heartburn)?	Yes No
17. Do you have Arthritis?	Yes No
18. Have you had Rheumatic Fever / jaw or neck stiffness?	Yes No
19. Have you sought treatment for Mental Health Issues?	Yes No
20. Have you taken cortisone drugs in the last six months?	Yes No
21. Do you smoke? If YES amountPer day	Yes No
22. Do you drink alcohol? If YES amountPer day	Yes No
23. Do you take any medication, vitamins or supplements? If YES please list - use reverse side	Yes No
24. Do you have any difficulties standing unaided? – If YES please phone the Booking Officer at The Eye Hospital prior to the day of Operation to discuss.	Yes No

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DATE OF BIRTH.....PHONE.....

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