# Anaesthesia Questionnaire

Please provide the following information for review by Dr ..... .
This information will be used to plan a safe and effective anaesthesia.

Name: ..... DOB ...../...../..... Weight. ..... kg Height ..... cm

Address..... .Email……

Phone::..... Emergency Contact …….. Dentist:……

Surgery Date: ……./……./……. Rooms / CPH Procedure: …….....

Medicare No:…… Health Fund…….....

Have you now or in the past had any of the following: (tick all that apply)

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|---|---|---|---|
| ☐ Bronchitis | ☐ High Blood Pressure | ☐ Jaundice, Hepatitis | ☐ Denture / Bridges |
| ☐ Emphysema | ☐ Heart Attack .....year | ☐ Liver Disease | ☐ Contact Lenses |
| ☐ Asthma | ☐ Heart Murmur | ☐ Cancer | ☐ Glasses |
| ☐ Hay Fever | ☐ Heart Disease | ☐ Stomach / Bowel problems | ☐ Hard of Hearing |
| ☐ Sinus Infection | ☐ Bleeding tendency | ☐ Acid reflux | ☐ Hearing Aid |
| ☐ Abnormal Chest X-Ray | ☐ Abnormal ECG | ☐ Seizures / Epilepsy | ☐ Body Piercing |
| ☐ Shortness of breath | ☐ Blood Clots / DVT | ☐ Stroke | ☐ Depression |
| ☐ Sleep Apnea / Snoring | ☐ Heart Failure | ☐ Transient ischaemic attacks | ☐ Mental Illness |
| ☐ CPAP ☐ BIPAP | ☐ Pacemaker | ☐ Fainting | ☐ Latex Allergy |
| ☐ Smoking ..... years | ☐ Defibrillator | ☐ Arthritis | ☐ Blood Transfusion |
| ☐ Smoking ..... / day | ☐ Diabetes | ☐ Fractures of face, neck, back | ☐ Tablets |
| ☐ Smoking Quit ..... .... years | ☐ Insulin | ☐ Loose teeth / caps / crowns | ☐ Tuberculosis |
| ☐ Cough/ Cold/ Sore throat in the past 6 weeks | ☐ HIV AIDS | ☐ Back Pain / slipped disc / Sciatica | ☐ Relative with severe reaction to anaesthetic |
| ☐ Prosthetic Implants | ☐ Other Allergies | | |

| PAST SURGERIES | YEAR | COMPLICATIONS (If any) |
|---|---|---|
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| MEDICATIONS | DOSE / FREQUENCY | ALLERGIES (If any) |
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PLEASE READ AND SIGN: Answers to the above represent a true and complete history, to the best of my knowledge.

..... ..... .....

**Patient / Parent / Guardian** **Signature** **Date**