

Patient Questionnaire

Complete this form if you will be undergoing anaesthesia.



New Zealand Society of Anaesthetists
(Incorporated)



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:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
General Practitioner:		General Practitioner's phone no.	
NHI no.	Community Services Card no.	Expiry date:	
Is this an ACC claim? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide ACC no.			
Inpatient / Day care:		Date:	Place:
Surgeon:		Anaesthetist:	
Proposed surgery:			

HEALTH QUESTIONNAIRE

1. Your weight (kg):	2. Your height (metres):	4. Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", how many per day?
3. Do you suffer from, or have you ever suffered from, the following:		5. Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", how much? How often?
Chest pains / tightness or angina <input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of breath <input type="checkbox"/> Yes <input type="checkbox"/> No	6. Risk of exposure to hepatitis? <input type="checkbox"/> Yes <input type="checkbox"/> No
Previous rheumatic fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	
Previous heart attack <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema or bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No	
Palpitations <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart murmur <input type="checkbox"/> Yes <input type="checkbox"/> No	Obstructive sleep apnoea <input type="checkbox"/> Yes <input type="checkbox"/> No	
High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Persistent cough <input type="checkbox"/> Yes <input type="checkbox"/> No	
Artificial heart valve or pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke or seizures <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hiatus hernia / heartburn / indigestion <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice or hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes – oral medication <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid disease <input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes – insulin-dependent <input type="checkbox"/> Yes <input type="checkbox"/> No	Previous DVT or lung embolus <input type="checkbox"/> Yes <input type="checkbox"/> No	
Kidney disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding or clotting disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	
Rheumatoid arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No	Motion sickness <input type="checkbox"/> Yes <input type="checkbox"/> 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?
e.g. diabetes, muscular dystrophy, malignant hyperthermia Yes No If "Yes", please list.

18. Have you or any of your family had problems with an anaesthetic? Yes No If "Yes", please outline.

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19. Do you suffer from any other condition, not covered elsewhere, that you feel we should know about? Yes No If "Yes", please outline.

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20. Do you have any concerns or questions about your anaesthetic? Yes No If "Yes", please outline.

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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:
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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: