Anaesthetic Questionnaire

Please complete in full

	Y/N	Details/Treatment
Allergy to medication, plaster, latex or food?		
Previous surgery		
Have you or any relatives ever experienced complications with anaesthesia?		
Do you or your family have porphyria, malignant hyperthermia, scoline apnoea, muscular dystrophy or myaesthenia gravis		
Have you ever had epilepsy, blackouts, a stroke or a TIA?		
Have you ever had high blood pressure, angina, palpitations, heart failure, heart attacks, heart valve trouble, stents or heart surgery?		
Have you ever suffered from asthma, emphysema, breathing difficulty, TB or other lung disease? Recent colds/flu		
Do you snore heavily or have sleep apnea?		
Do you exercise? Are you able to walk up 2 flights of stairs (24 steps) without resting?		
Do you have diabetes or thyroid problems?		
Do you have osteoarthritis, SLE (lupus) or rheumatoid arthritis?		
Do you have kidney or liver problems?		
Do you have acid reflux, heartburn, hiatus hernia or ulcers?		
Have you ever had a thrombosis in your legs (DVT) or clots in the lungs		
Do you have any bleeding problems?		
Are you taking any blood thinning medications (like warfarin/clopidogrel(plavix)/xeralto/Pradaxa/aspirin)?		
Previous chemotherapy or radiotherapy?		
Have you taken cortisone/prednisone or other steroid medications in the last 12 months?		
Do you smoke? How many cigarettes daily?		
How much alcohol do you consume daily/weekly?		
What is your body weight? What is your height?		**_____kg _____,_____m**
Is there anything else that your anaesthetist should be aware of?		

Current medications (name and dosage) Include herbal and non prescription medication

Name_____Signature_____Date_____

Please contact our office if you would like an estimate of the anaesthetic fee for your planned operation.