# Pre-Operative Questionnaire for Anaesthesia or Sedation

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The fastest and easiest way to complete this form and to ensure it reaches your anaesthetist on time is through the online version at drrosshanrahan.com. Use this form if you can't use the online version.

## Consent to Review Your Medical Records

Do you provide consent for your Anaesthetist to contact your other doctors and review your medical records and test results for the purpose of tailoring your anaesthetic for the planned procedure?

- [x] Yes
- [ ] No (Please send details of your concerns via the addresses near the logo)

## Personal Details

**Name:** *(first name)* .....*(last name)* .....

**DOB:** ...../...../..... **Weight** *(kg or stone)*: ..... **Height** *(cm or feet/inches)*: .....

**Address:** .....*(street address)*.

.....*(suburb)*..... *(state)* ..... (postcode)

**Preferred Phone Number:** .....

**E-Mail Address:** .....

## Insurance Details

**Medicare Number:** .... .... .... .... .... .... .... .... .... .... **Position on card:** .... **Expiry:** ..... / .....

- [ ] **Privately Insured -** ***Private Health Fund:*** ..... ***Fund Membership Number:*** .....
- [ ] **Dept of Veterans Affairs (DVA) -** ***DVA Number*****:** .....
- [ ] **WorkCover -** ***Claim Number*****:** ..... [ ] **Defence**
- [ ] **Uninsured or Privately Funded**

## Attaching or uploading documents

If you already have a document with your medical history or medications, you can send it with this form, or upload it at *drrosshanrahan.com*. Please still read all the questions, and say "*see medication list*" etc if the answers are in your upload.

- [ ] I have attached ..... documents containing information about .....

.....

## Your Planned Procedure

**Name of Surgeon or proceduralist:** .....
includes gastroenterologist, cardiologist etc

**What Date is Your Operation/ Procedure Planned:** ...../...../.....

**In your own words, explain what procedure you're expecting to have:**

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## Previous Operations, Procedures and Anaesthetics

**What (if any) Previous Operations or Procedures Have You Undergone?**
have you previously had a procedure similar to the one you're planned for?

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**Have you ever had problems with previous anaesthetics or procedural sedation?**
eg nausea, allergic reactions, slow to wake up, unintentional awareness. have any family members had bad reactions to anaesthesia?

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## Current Level of Fitness

**Describe the most strenuous activity you have performed in the last 2 months.**
eg: climbing up 2 flights of stairs, using a push mower, making the bed, going for a 1 hour walk

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If you're not very active, what prevents you from doing more? (eg joint pain, being short of breath, tired)

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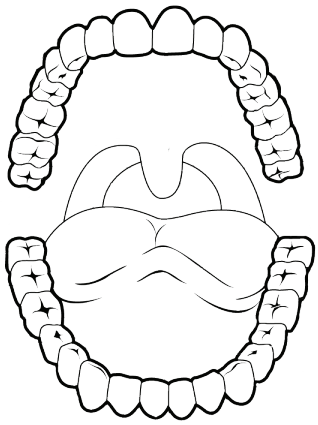
## Questions Related to Your Airway

**Do you have any False Teeth, Dentures, Dental Caps, Veneers or Bridges?**
**Any Broken, Loose or Missing Teeth?** Which teeth?



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**Do you have a beard or any facial/ tongue piercings?**

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## Medical History

**Do You Have a History of Any Medical Conditions?**
If you have a serious or complex issue, please include the names of any other Doctors involved in management

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**Screening Questions.**
Make sure you haven't forgotten to mention any of the conditions below.

### Heart Conditions
- ☐ Heart Attacks
- ☐ Angina or Chest Pain on Exertion
- ☐ Heart Murmurs
- ☐ Irregular Heart Rate (Palpitations)
- ☐ Fluid on the Lungs (Pulmonary Oedema)

### Lung Conditions
- ☐ Asthma
- ☐ COPD, Emphysema or Chronic Bronchitis
- ☐ Recent Chest or Throat Infection
- ☐ Currently a Smoker
- ☐ History of Smoking for more than 5 years
- ☐ Obstructive Sleep Apnoea

### Gut Conditions
- ☐ Heartburn or Reflux
- ☐ Stomach Ulcers
- ☐ Liver Problems

### Other Conditions
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Seizures
- ☐ Strokes or TIAs
- ☐ Kidney Disease
- ☐ Chronic Pain Conditions

☐ Is there any chance you could be pregnant?

## Medications

**Are You Allergic or Intolerant of any Medications, Tapes or Other Substances**

| Medication/ Substance | Reaction to Exposure |
|---|---|
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**Current Medications**

You can attach a medication list if you have one and simply say "see list"

If you take a blood thinner, include *why* it was prescribed (eg prevent heart attacks, previous clot in leg)

| **Medication Name** | **Medication Stength** eg 500mg, 20/10, 250/50 | **Dose Taken** eg: one 500mg tablet each morning 1-2 tablets twice a day as needed |
|---|---|---|
| *Example:* Nexium | 40mg tablets | 1 tablet (40mg) before bed |
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## Questions

**Do you have any particular questions or want to mention anything not covered elsewhere?**

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*Name:* *Signature:* *Date:* / /