



Name: _____	NHI: _____

Sex: _____	DOB: _____
Hospital: _____	

(Attach Patient Label or complete details)

Have you or your child ever had any of the following?
If yes, please write when you had the problem.

CONDITION	YES	NO	DETAILS
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Heart Disease e.g. angina, chest pains, arrhythmia, congenital heart defects, heart murmur etc	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Heart Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Asthma / Bronchitis If yes, have you ever been hospitalised with either?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No	_____
Lung Disease e.g. emphysema, TB etc	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Diabetes If yes, do you take insulin? Do you take diabetic tablets?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No	_____
Liver Disease e.g. jaundice, hepatitis etc	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Blackouts or Fainting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Epilepsy or Convulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Blood Clots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Abnormal Bleeding or Bruise Easily	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Anaemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Rheumatoid Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Hiatus Hernia, Heartburn, Indigestion or Acid Reflux	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Persistent Pain If yes, state location / intensity / duration.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Problems with your bladder or bowel When and what?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

Please give details for the following:	YES	NO	DETAILS
Weight (kg): _____			Height (cm): _____
Do you or have any of your family members had problems with anaesthetic?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Are you currently taking any prescribed medications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Do you have any allergies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Do you have problems with motion sickness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Do you drink alcohol? If yes, number of drinks per day.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Do you take street drugs or narcotics?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Do you believe you could be pregnant? If yes, how many weeks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Do you have any other health problems not already mentioned above? e.g. infectious conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Do you have any developmental / behavioural problems that we need to be aware of?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____



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Do you have any concerns about your / your child's / your ward's operation / procedure?

If yes, please detail:

Do you have any special concerns / requests regarding your admission?

Have you or your caregiver:

- Completed the Pre-operative Questionnaire?

I understand:

All proposed treatments will be clearly explained to me / my legal gardian and consent will be obtained from me / my legal guardian. (Written consent may be required before certain treatment interventions are initiated). There will be ongoing discussion with me /my legal guardian and liaison between health professionals in relation to my treatment or care.

I /my legal guardian have the right to refuse any treatment or withdraw consent to treatment at any time.

I must not drive for 24 hours after my anaesthetic.

I must not operate heavy machinery or undertake major decisions within 24 hours of my operation.

I will make arrangements for a designated caregiver for a 24 hour period.

Have you or your caregiver received:

- The pre-operative form on fasting guidelines.
- Education / information regarding the procedure.
- The brochure on "Patient Information"

Signed (Patient / Legal Guardian

Date

or

Patient / Legal Guardian unable to sign because:

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