|  |  |  |
| --- | --- | --- |
| **Health Assessment Form** | SURNAME | URN |
| GIVEN NAME | DOB |
| SEX: Male / Female | TELEPHONE |
| ADDRESS | |

**Procedure**:

Please list **ALL MEDICINES** you are taking now, including pain-killers, puffers, warfarin, insulin, herbal, and over the counter products

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name | Dose | How often? | Name | Dose | How often? |
| 1. |  |  | 5. |  |  |
| 2. |  |  | 6. |  |  |
| 3. |  |  | 7. |  |  |
| 4. |  |  | 8. |  |  |

**Please answer the following questions**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No |  |
| 1. Are you allergic to any medicines? |  |  | Which ones? |
| 2. Do you take any unprescribed drugs? |  |  | Which ones? |
| 3. Do you smoke cigarettes |  |  | How many per day? How many yrs? |
| 4. Have you quit smoking? |  |  | When did you quit? Year |
| 5. Do you drink alcohol  - Have you ever had a problem with alcohol?  - Have you ever had a problem with  drugs? |  |  | How many per day? How many yrs?  - Describe:  - Describe: |
| 6. Have you ever tested positive for HIV? |  |  | Describe: |
| 7. Have you ever tested positive for hepatitis |  |  | Describe: |

**Please list all operations and recent tests (last 12 months) that you have had**

|  |  |  |  |
| --- | --- | --- | --- |
| Surgery/ Test | Date | Surgery/ Test | Date |
| 1. |  | 4. |  |
| 2. |  | 5. |  |
| 3. |  | 6. |  |

**Do you have or have you ever had any of the following?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Yes | Unsure | No | Details |
| 1. A bad reaction to an anaesthetic? |  |  |  |  |
| 2. Have you ever suffered awareness during a  past anaesthetic? |  |  |  |  |
| 3. A member of your family with a bad reaction to an anaesthetic (e.g. malignant  hyperthermia?) |  |  |  |  |
| 4. A member of your family with a bleeding  problem |  |  |  |  |
| 5. High blood pressure |  |  |  |  |
| 6. Chest pains, angina or a heart attack |  |  |  |  |
| 7. A pacemaker/implanted defibrillator |  |  |  |  |
| 8. Short of breath walking or going up stairs? |  |  |  |  |
| 9. Asthma, bronchitis, or breathing problem |  |  |  |  |
| 10. Do you have obstructive sleep apnoea? |  |  |  |  |
| 11. Clots in legs or lungs? |  |  |  |  |
| 12. Stroke, faints, blackouts or dizzy spells? |  |  |  |  |
| 13. Migraine headaches? |  |  |  |  |
| 14. Back, joint or neck problems |  |  |  | Back Joint Neck |
| 15. Muscle disease, arm or leg weakness |  |  |  |  |
| 16. Diabetes? |  |  |  |  |
| 17. Kidney problems? |  |  |  |  |
| 18. Hepatitis or liver problems? |  |  |  |  |
| 19. Hiatus hernia, reflux or heartburn? |  |  |  |  |
| 20. Easy bruising or bleeding problem? |  |  |  |  |
| 21. Are you pregnant? |  |  |  |  |
| 22. Any other serious illness or disability? |  |  |  |  |
| 23. Do you wear dentures? |  |  |  |  |
| 24. How much do you weigh? |  |  |  | kg |
| 25. Do you have someone at home to care for  you after procedure? |  |  |  | Who? |
| 26. Family history of cancer |  |  |  |  |

I confirm that the information provided in these forms is true and correct to the best of my knowledge

Name Signature Date (dd/mm/year)