

# Some questions before your procedure

## Your safety

Australia is one of the safest places in the world to have an anaesthetic.

I aim to make your procedure as stress-free as possible with a safe, rapid and uneventful recovery.

Please answer the questions as honestly as you can. The answers you provide will help to make your anaesthetic as safe as possible.

Please be reassured that the information you provide will be treated as strictly confidential.

## Contact

Capricornia Anaesthesia in association with Adelaide Anaesthetic Services at:

T: [08 8139 0600](tel:0881390600)

E: [bookings@capricornia.online](mailto:bookings@capricornia.online)

Name:		Your procedure:	
Mobile:		Procedure date:	
Address:		Surgeon:	
email:		Hospital:	
DOB:		Health Fund Name:	
Height:		Health Fund No:	
Weight:		Medicare No:	
		Pensioner:	

### Introduction

No/Yes If 'YES' please provide details

Have you had an anaesthetic before?		
Have you had problems with anaesthetics?		
Any blood relatives had problems with anaesthetics?		
Any family history of inherited diseases?		

### Heart and circulation

No/Yes If 'YES' please provide details

Blood pressure, high cholesterol?		
Angina, heart attack, heart surgery, bypass grafts, valve surgery?		
Atrial fibrillation, irregular heart beat, pacemaker, internal defibrillator?		
Heart failure?		

### Breathing and lungs

No/Yes If 'YES' please provide details

Asthma, emphysema?		
Sleep apnoea, CPAP (if so, please bring your CPAP machine with you)?		
Have you had COVID-19 in the last 6 weeks?		
Have you been unwell with a cough/cold?		

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General medical	No/Yes	If 'YES' please provide details
Females: any chance of being pregnant?		
Any gastric reduction (bariatric) surgery?		
Any stomach ulcers or hiatus hernia?		
Reflux or heartburn?		
Neck or jaw problems?		
Any other medical issues?		

Brain and nerves	No/Yes	If 'YES' please provide details
Have you had a stroke or mini-stroke (TIA)?		
Do you have Parkinson's disease?		
Any other neurological disease?		

Endocrine	No/Yes	If 'YES' please provide details
Diabetes? If so, Type 1 or 2?		
: if you have diabetes, any complications?		
Have you had any thyroid problems?		
Rheumatoid Arthritis or other joint problems?		
Any other neurological disease?		

Miscellaneous	No/Yes	If 'YES' please provide details
Have you had any blood clots (DVT, Pulmonary embolus)?		
Neck or jaw problems?		
Have you had any form of cancer?		
Any other medical issues?		

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Medications and drugs	No/Yes	If 'YES' please provide details
Do you smoke cigarettes? If so, how many, and for how long have you smoked?		
Do you drink alcohol? If so, how much daily?		
Do you take recreational drugs?		
Do you take medication for diabetes? If so, please list them:		
If you take medications for diabetes, do any of your tablets contain drugs with "flozin" in their names?		
Do you take any heart medication? If so, please list them:		
Do you take any blood thinners? If so, please list them"		

Other medications and allergies?	Please list all medications not recorded above:	
	and allergies to any medications:	

Name of person who completed this form	date	signature

Are you happy for me to contact other doctors, if necessary, about your medical conditions (medical consent)	
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If you are using Adobe software, you can lock your answers by clicking here:

And if your device allows, electronically submit this form by clicking here:

Otherwise please email this form to: [bookings@capricornia.online](mailto:bookings@capricornia.online)

For any questions, please call us on 08 8130 0600

