Stace Anaesthetists

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Please answer all questions and return in the reply paid envelope			
Name:		Today's Date:	
Address:		Operation:	
Date of Birth:		Date of Surgery:	
Telephone:		Surgeon:	
Name of GP:		Contact No. for GP:	
Medicare No:		Please circle : ***Hospital / Extras / Both***	
Health Fund:		Membership No:	
Aged Pension No:		Email Address:	

SURGICAL HISTORY

Year	Surgery	Problems	Year	Surgery	Problems

IMPORTANT PLEASE COMPLETE **WEIGHT:** kgs **HEIGHT:** cms

MEDICAL CONDITIONS do you have or have you ever suffered from:

☐ High Blood Pressure	☐ Sleep Apnoea	☐ Bleeding Problems
☐ Heart pacemaker etc	☐ Heartburn/Indigestion	☐ Blood Clots
☐ Heart murmurs/palpitations	☐ Diabetes I/II	☐ Rheumatoid Arthritis
☐ Heart attacks/strokes	☐ Epilepsy	☐ Gastric Banding
☐ Asthma	☐ Limited Neck/Jaw Movement	☐ Infectious Disease (HIV etc)
☐ Lung Problems	☐ Liver/Kidney Problems	☐ Females – Are you pregnant

Describe:

LIST YOUR PRESCRIBED DRUGS incl OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS

Drug	Strength	Frequency	Drug	Strength	Frequency

HEALTH HABITS

Do you smoke?	☐ Y	☐ N	Per day
Do you have crowned/capped/false teeth?	☐ Y	☐ N	
Do you drink alcohol?	☐ Y	☐ N	Per day
Allergies, reactions to drugs, tapes, foods?	☐ Y	☐ N	

Please list allergies:

ANY SIGNIFICANT FAMILY HISTORY (PARTICULARLY WITH ANAESTHESIA)

Alternatively, a "Health Summary" from your GP would be appreciated!

Please turn over and write on the back of this form if needed.