Please answer all questions and return in the reply paid envelope					
Name:		Todays Date:			
Address:		Operation:			
Date of Birth:		Date of Surgery:			
Telephone:		Surgeon:			
Medicare No:		HEIGHT	cms	WEIGHT	kgs
Health Fund:		Membership No:			
Aged Pension No:					

SURGICAL HISTORY					
Year	Surgery	Problems	Year	Surgery	Problems

MEDICAL CONDITIONS (Please List/Tick Current & Previous)		
High Blood Pressure	Sleep Apnoea	Bleeding Problems
Heart palpitations	Heartburn/Indigestion	Blood Clots
Heart murmurs	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

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!