Pre Anaesthetic Patient Record

SIGNATURE EYE SPECIALISTS

Name: _____
Address: _____
_____
AHC#: _____
DOB: _____ Phone #: _____

To Be Completed By Patient

YES NO

1 Have you had a previous general anaesthetic?
Have you had a previous region anaesthetic (epidural, spinal, eye block)?

Year	Operation	Type Of Anaesthetic	Hospital

2 Have you ever had any complications from anaesthetic?
STATE: _____

3 Have any members of your family ever had any complications from an anaesthetic?
STATE REACTION: _____

4 Do you have any known allergies?
Please list and state reaction: _____
_____

5 Do you take any medications?
Please list: _____
_____
_____

6 Have you ever been on steroids (e.g., Prednisone, Cortisone)?
If so, when? _____

7 Have you ever had Heart Disease?

- Rheumatic Fever
- Heart Attack (when?) _____
- Angina (chest pain)
- High Blood Pressure
- Heart Murmur
- Other (specify) _____

8 Have you ever had Lung Disease?

- Asthma
- Chronic Bronchitis
- Emphysema
- Pneumonia
- Tuberculosis
- Other (specify) _____

To Be Completed By Patient

Patient Name _____

YES NO

9 Do you smoke?
If so, how much per day, how long? _____
if no, did you smoke?
When did you quit? _____

10 Do you use cannabis?
If so, how often? _____

11 Have you ever suffered from any of the following (if yes, state when)

Liver Disease, Hepatitis, Jaundice _____
Diabetes _____
Kidney Disease _____
Thyroid Disease _____
Seizures, or Blackouts, or Stroke _____
Glaucoma _____
Heartburn _____
Arthritis _____

12 Teeth: Any Loose teeth?
Capped teeth (crowns)?
Dentures?
Bridgework?

13 Any history of alcohol or drug abuse?
(Specify) _____

14 Can you walk one mile?
Up three flights of stairs?

15 Have you had an electrocardiogram within the last six months?

16 Have you had a chest x-ray within the last year?

17 Is there any chance you may be pregnant now?
Date of your last menstrual period: _____

18 What is your weight? _____ Kg or _____ lbs.
What is your height? _____ cm or _____ ft.

Date: _____ Signature: _____