Dr. Kara
PLASTIC SURGERY

ANAESTHEISA QUESTIONNAIRE

PLEASE PRINT CLEARLY

FAMILY NAME:_____ GIVEN NAME _____
ADDRESS:_____
TELEPHONE: Home_____ Work: _____ Cell: _____
IDEAL SURGERY DATE:_____
SEX: M F DATE OF BIRTH:_____ MARITAL STATUS _____
ALLERGIES:_____
FAMILY PHYSICIAN:_____ PHONE NUMBER: _____
PERSON TO NOTIFY IN CASE OF EMERGENCY: _____
RELATIONSHIP:_____PHONE NUMBER:_____

HEALTH CARD NUMBER:_____ VERSION CODE_____

PRE ADMISSION MEDICATION LIST:

Record All medications/prescriptions including vitamins and herbal supplements

	MEDICATION NAME	STRENGTH	DIRECTIONS
1			
2			
3			
4			
5			
6			
7			

IF YOU ARE UNABLE TO COMPLETE THIS FORM, ASK YOUR PHARMACIST FOR ASSISTANCE

PATIENTS WEIGHT:_____ HEIGHT:_____

HAVE YOU EVER HAD ANAESTHETIC BEFORE?_____ WHEN WAS THE LAST TIME?_____
HAVE YOU OR A RELATIVE EVER HAD AN UNUSUAL REACTION TO AN ANAESTHETIC?_____
IF YES, PLEASE SPECIFY:_____
DO YOU HAVE A LATEX OR TAPE ALLERGY?_____ IF YES, PLEASE SPECIFY:_____

ARE YOU ALLERGIC TO ANY MEDICATION OR OTHER SUBSTANCES? _____

SUBSTANCE:	REACTION:

HAVE YOU HAD A COLD IN THE LAST MONTH?_____

DO YOU HAVE, OR EVER HAD: (PLEASE CIRCLE YES OR NO)

HEART MURMUR?	YES	NO
HIGH BLOOD PRESSURE?	YES	NO
ANGINA OR HEART ATTACK?	YES	NO
CHRONIC BRONCHITIS OR EMPHYSEMA?	YES	NO
TUBERCULOSIS?	YES	NO
ANY OTHER LUNG TROUBLE?	YES	NO
ANEMIA?	YES	NO
SICKLE CELL DISEASE?	YES	NO
JAUNDICE OR LIVER TROUBLE?	YES	NO
PROBLEMS WITH EASY BRUISING?	YES	NO
BACK INJURY/BACK PROBLEM?	YES	NO
A SEIZURE DISORDER?	YES	NO
A STROKE OR 'TIA's"?	YES	NO
POLIO PARALYSIS OR MENINGITIS?	YES	NO
THYROID TROUBLE?	YES	NO
DIABETES?	YES	NO
HIATUS HERNIA?	YES	NO
KIDNEY PROBLEMS?	YES	NO

DO YOU, OR HAVE YOU EVER HAD ANY SERIOUS ILLNESS NOT MENTIONED ABOVE?

_____

_____

LIST ALL PREVIOUS SURGERIES THAT YOU HAVE HAD:

1) _____
2) _____
3) _____
4) _____
5) _____

DO YOU SMOKE CIGARETTES? _____ IF YES, HOW MANY PER DAY? _____

When did you quit?_____

DO YOU DRINK ALCOHOL?_____ IF YES, HOW MANY PER WEEK?_____

DO YOU TAKE OR HAVE YOU EVER TAKEN ADDICTING DRUGS?_____

If yes, have you ever had treatment for alcohol or drug dependency? _____

DO YOU HAVE ANY CAPS, CROWNS, BRIDGES, REMOVABLE DENTAL WORK OR LOOSE TEETH?

_____

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ARE YOU TAKING, OR HAVE YOU TAKEN?

	NOW	IN PAST 2 YEARS	NAME/DOSAGE
MEDICATION FOR HEART?			
MEDICATION FOR BLOOD PRESSURE?			
MEDICATION FOR BREATHING?			
DIURETIC OR WATER PILLS?			
STERIODS, CORTISOL OR ACTH?			
DIABETIC MEDICATION?			
THYROID MEDICATION?			
ASPIRIN/ANTI-INFLAMMATORIES?			
BLOOD THINNERS OR ANTICOAGULANTS?			
MEDICATION FOR STOMACH/DIGESTION?			
PAIN PILLS OR SHOTS?			
ANTIDEPRESSANTS?			
TRANQUILIZERS OR SEDATIVES TO SLEEP?			

PATIENT NAME: (Please Print) _____
PATIENT SIGNATURE: _____ DATE:_____

IN OFFICE USE ONLY
COMMENTS _____
_____
_____
_____
_____
_____


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