2 One Six One Medical Group
Anaesthetic Assessment Form

IMPORTANT -Please complete this form if you are undergoing a General or Local Anaesthesia and return to OneSixOne Medical Group by at least 7 days prior to your procedure. A delay in receiving this form could potentially delay your surgery date. Thankyou. OneSixOne Medical Group, 161 Gillies Ave, Epsom 1023. reception@onesixone.co.nz

Please answer all questions as accurately as possible. All information is sought to minimise your risk.					
Family Name:		First Name:			
Address:					
Contact phone no:	Date of Birth:		Male		Female
Email Address:		NHI:			
General Practitioner:		GP phone number:			
Proposed Surgery:		Date of Surgery:			
Surgeon:		Anaesthetist:			
ACC Claim: Yes – Claim No.		No	Insurance Company:		
Insurance No. /Claim No.		Partial Cover	Full Cover	Other	Self-Pay

Health Questionnaire

Your Weight (kg):		**Your Height (metres):**	

Do you suffer from, or have you ever suffered from, the following? Please Tick yes or No.

	✓		✓				✓		✓	
Chest pains/tightness or angina		Yes		No		Shortness of Breath		Yes		No
Previous rheumatic fever		Yes		No		Asthma		Yes		No
Previous Heart attack		Yes		No		Emphysema/bronchitis		Yes		No
Palpitations		Yes		No		Tuberculosis		Yes		No
Heart Murmur		Yes		No		Obstructive sleep apnoea		Yes		No
High Blood Pressure		Yes		No		Persistent Cough		Yes		No
Artificial Heart valve/Pacemaker		Yes		No		Stroke or Seizure		Yes		No
Hiatus Hernia/Heartburn/Indigestion		Yes		No		Jaundice or Hepatitis		Yes		No
Diabetes		Yes		No		Thyroid Disease		Yes		No
Kidney problems		Yes		No		Previous DVT or Lung embolus		Yes		No
Rheumatoid Arthritis		Yes		No		Bleeding or clotting disorder		Yes		No
						Motion sickness		Yes		No

If you have answered "yes" to any of the above, please give further details below.

Do you smoke?	Yes - How many/day?	No - If you stopped, when?
Do you drink alcohol ?	Yes – How often	No

Please list previous surgery, including year and hospital if known.

Surgery	Date	Hospital

2 One Six One Medical Group
Anaesthetic Assessment Form

Name of Patient:		
What medications (including herbal) are you taking? Please list below		
Medication	Dose	Time taken
Do you have any problems opening your Mouth ?		
Have you been told of any difficulties during your anaesthetic?		
Do you have dentures, partial plate, capped or loose teeth?		
What physical activities do you take part in on a regular basis? Walking Gym work Tennis Golf Other		
How many flights of stairs can you climb without getting out of breath? One Flight Two flights Three Flights		
My activity is restricted by: Shortness of Breath Chest Pain Joint Pain		
Do you have any allergies to medications, tablets, plasters, food, Latex or any other substance? Please list.		
Are there any other major illnesses, to your knowledge, among your blood relatives? E.g.: diabetes, muscular dystrophy, malignant hyperthermia?		
Have you or any of your family had problems with an anaesthetic?		
Do you suffer from any other condition, not covered elsewhere, that you feel we should know about?		
Do you have any concerns about your anaesthetic?		
Are you or could you be pregnant? Yes No		
Signature		
I give permission for my/my child's medical records and investigation results to be accessed for the purpose of assisting my anaesthetic. Yes No		
The above details have been completed by: Patient Guardian Relative Other		
Signature:	Date:	Print Name: