SPRING HILL SPECIALIST DAY HOSPITAL

Levels 1 and 4, St Andrew's Place
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PATIENT I.D. LABEL

PRE-OPERATIVE FORM

PRE-OPERATIVE ASSESSMENT FORM

PLEASE COMPLETE THIS FORM IN BLACK PEN AND RETURN IT TO THE DAY SURGERY UNIT AS SOON AS POSSIBLE.
IF TIME IS INADEQUATE, PLEASE BRING IT WITH YOU ON THE DAY OF SURGERY.

Name: **Ht:** cm **Wt:** kg

Details of previous surgery: ______

Have you had an anaesthetic previously? ☐ Yes ☐ No

If Yes please give details of any problems: ______

Gyn/IVF patient only

Date of last menstrual cycle: ____ / ____ / ____ Are you currently breast feeding? ☐ Yes ☐ No

Do you have or have ever had any of the following? *(Circle answer where there are options)*	Yes	No	Additional information
Allergies to medication / tapes / dyes / latex / food	☐	☐	
Malignant hyperthermia (you or your family)	☐	☐	
A cough or cold at present	☐	☐	
Heart disease, Rheumatic fever, Heart Murmur	☐	☐	
Chest Pain / Angina / Heart Attack / High Blood Pressure	☐	☐	
Bronchitis, Asthma, or any other chest problems	☐	☐	
Do you smoke? How long?	☐	☐	
Faint easily	☐	☐	
Epilepsy or other seizures	☐	☐	
Hepatitis or jaundice	☐	☐	
Arthritis or muscle disease	☐	☐	
Kidney problems	☐	☐	
Heartburn / reflux	☐	☐	
Anaemia or other blood problems	☐	☐	
Bruise or bleed easily	☐	☐	
Diabetes Type 1 Type 2	☐	☐	
Have you taken Aspirin in the last 2 weeks	☐	☐	
Other serious illnesses or disabling conditions	☐	☐	

List of current medications (including alternative / recreational drugs): ______

Special diet? If yes please give details: ______