NHI Number: DOB:

NEUROLOGICAL	YES	NO
Epilepsy		
Seizures		
When was your last seizure?		
Severe headaches		
Stroke		
Trans Ischemic Attack (TIA)		
When was last stroke/TIA?		
Blackouts		
Alzheimers		
Dementia		
Mental health condition		
Neurological condition		
Please Specify		
History of dura mater implants prior to 1992		
History of Neurosurgery prior to 1992		
Are you or have you in the past taken human derived growth hormone?		
Which country was the derived growth hormone from?		

MEDICINES
List ALL current medicines, tablets, inhalers, injections, eye drops, herbal remedies, homeopathic, complementary and alternative medicine (CAM) e.g. garlic, ginseng, ginkgo; vitamins and other supplements

GENERAL	YES	NO
Hepatitis		
What type of Hepatits?		
Tuberculosis		
How long ago?		
HIV / AIDS		
Psoriasis/Dermatitis		
Please Specify		
Skin ulcers/Current Wounds/Dressings		
Please Specify		
Current Skin Infections		
Please Specify		
Hospital Acquired Infections e.g MRSA/ESBL/VRE		
Claustrophobia		
Do you smoke?		
Do you consume alcohol?		
How many glasses/week?		
Do you take social/recreational drugs?		
Please specify and how often?		
Do you have any religious beliefs/practice or cultural needs that we should be aware of?		
Please specify		
Do you have any dietary requirements?		
Please specify		
Any other relevant or helpful health information you may wish to advise us of?		
Please specify		
How are you feeling about your upcoming procedure?		

LIST ALL HOSPITAL ADMISSIONS/OPERATIONS DURING THE PAST 5 YEARS

Name of Hospital	Month/Year	Reason for Admission

Questionnaire completed by (Please circle): Patient / Family Member / Reception / Bookings Clerk / GP / Nurse

☐ **CONSENT: To the best of my knowledge the above information is correct and I authorise the use of this information for purposes directly related to my healthcare**

Name: _____ Signature: _____ Date: _____

Part of the AUCKLANDEYE group

ADULT GENERAL ANAESTHETIC/IV SEDATION Form

Patient Label

HEIGHT: WEIGHT:

THE FOLLOWING QUESTIONS ARE FOR PATIENTS UNDERGOING GENERAL ANAESTHETIC OR IV SEDATION NB: YOU WILL REQUIRE ADULT SUPERVISION FOR 24 HOURS AFTER GENERAL	YES	NO
Will you be undergoing General Anaesthetic or IV Sedation during your surgery with Auckland Eye?		
Have you had General Anaesthetic or IV Sedation in the past?		
What type of anaesthetic have you had in the past?		
Have you or any family member had any problems with previous anaesthetics?		
Family member had problems with previous anaesthetics, please explain		
Do you suffer from motion sickness?		
What level of motion sickness		
Do you have problems opening your mouth?		
Previous jaw problems/injuries?		
Please specify		
Do you have dentures / partial plates / capped or loose teeth?		
Please specify		
Is your physical activity restricted by shortness of breath / chest pain / joint pain?		
Please specify		
Do any of your blood relatives have any major illnesses?		
Please specify		
Do you have any specific questions you wish the Anaesthetist to answer prior to your surgery?		
Please outline your questions for the Anaesthetist		

Questionnaire completed by (Please circle): Patient / Family Member / Reception / Bookings Clerk / GP / Nurse

☐ **CONSENT: To the best of my knowledge the above information is correct and I authorise the use of this information for purposes directly related to my healthcare**

Name: _____ Signature: _____ Date:_____