onsis
Part of the AUCKLANDEYE group

ADULT PRE-OP
HEALTH QUESTIONNAIRE

Patient Label

HEIGHT: WEIGHT:

BMI:
Office use only

Please tick "YES" or "NO" for each line and circle the appropriate condition **Have you ever, or do you currently have, any of the following?:**

CARDIAC	YES	NO
High blood pressure?		
Low blood pressure?		
Do you take blood pressure medications?		
Angina / Chest Pain / Palpitations?		
The last episode:		
Heart attack?		
Coronary surgery or procedures?		
Stent		
Artificial heart valve		
How long ago since your previous heart attack, coronary surgery, stent, or artificial heart valve?		
Heart murmur		
Defibrillator		
Pacemaker		
How long ago was it inserted?		
Blood thinning medication e.g Warfarin or Pradaxa		
Please specify		
Blood disorder: Bruise easily		
Blood disorder: Anaemia		
Blood disorder: Blood clots in legs or lungs		
How long ago?		

ALLERGIES, REACTIONS OR SENSITIVITES	YES	NO
Do you have any allergies, reactions or sensitivities?		
Are you allergic to drugs and/or medicine?		
Name and reaction you have to drugs and/or medicine		
Are you allergic to latex?		
Reaction you have to latex		
Are you allergic to iodine?		
Reaction you have to iodine		
Are you allergic to plaster?		
Reaction you have to plaster		
Are you allergic to food?		
Name and reaction you have to food		

RESPIRATORY	YES	NO
Shortness of breath		
On exertion or rest?		
Persistent cough		
On exertion or rest?		
Asthma		
When was your last asthma attack?		
Emphysema / Chronic Pulmonary Disease (COPD) / Obstructive Sleep Apnoea (OSA)		
Please specify		
Diabetes		
How do you manage? (Please circle) Tablets / Diet controlled / Insulin		
Hiatus hernia		
Heart burn		
Stomach ulcer		
Kidney disease		
Renal failure		
Dialysis		
Bladder problems		
Bowel problems		

MOBILITY	YES	NO
Do you require mobility assistance?		
Please specify		
Do you have difficulty getting off a bed?		
Please specify		
Do you have any difficulty lying flat?		
Please specify		
Do you use a walker / stick / wheelchair? (Please circle)		
Please specify		
Are you prone to falls?		
How long ago was your last fall?		
Are you prone to fainting?		
Do you have any implants or prostheses?		
What implants or prostheses do you use?		
Women - Are you or could you be pregnant?		

NHI Number: DOB:

NEUROLOGICAL	YES	NO
Epilepsy		
Seizures		
When was your last seizure?		
Severe headaches		
Stroke		
Trans Ischemic Attack (TIA)		
When was last stroke or 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?		

CURRENT MEDICATIONS	
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	
1.	9.
2.	10.
3.	11.
4.	12.
5.	13.
6.	14.
7.	15.
8.	16.

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 / Other

☐ **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: _____

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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 ANAESTHETIC	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?		
Please specify		
Do you suffer from motion sickness?		
What level of motion sickness? (please circle) Mild / Moderate / Severe		
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 / Other

☐ **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:_____