

QFG DAY THEATRES	PATIENT I.D. LABEL
1st & 4th Floors St Andrew's Place 33 North Street Spring Hill 4000 Phone: (07) 3307 3243 Fax: (07) 3832 3247	

PRE-OPERATIVE ASSESSMENT FORM

**PLEASE COMPLETE THIS FORM 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	Females Only
					Date of last menstrual cycle / /
Have you had an anaesthetic previously? Yes / No					Are you currently breastfeeding Y / N
If yes, please give details of any problems					

DO YOU HAVE OR HAVE EVER HAD ANY OF THE FOLLOWING?					
	Yes	No			
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? For how long					
Faint easily					
Epilepsy or other fits					
Hepatitis or jaundice					
Arthritis or muscle disease					
Kidney problems					
Heartburn/reflux					
Anaemia or other blood problems					
Bruise or bleed easily					
Diabetes					
Have you taken aspirin in the last 2 weeks					
Allergies to medication/tapes/dyes					
Other serious illnesses or disabling conditions					
Details of previous surgery					
List of current medications (Including alternative/recreational drugs)					
Special diet, if yes please give details					

