

Patient to Complete

SURNAME.....

GIVEN NAMES.....

DATE OF BIRTH

Please fill in if no Patient Label available

Do you have or have you ever had any of the following

No Yes

9. Are you being treated by a Lung / Respiratory Specialist ☒ ☐ Last Visit/...../.....

(b) What is the Specialist's name / Phone No.....

10. Do you smoke ☒ ☐ How many per day

11. Are you an ex-smoker..... ☒ ☐ When did you stop

12. Asthma or shortness of breath (please circle)..... ☒ ☐ When

13. Bronchitis or emphysema (please circle)..... ☒ ☐ When

14. Pneumonia or tuberculosis (T.B.) (please circle)..... ☒ ☐ When

15. Obstructive sleep apnoea as diagnosed by your doctor..... ☐ ☒ CPAP Machine ☐ No ☐ Yes

16. Shortness of breath that prevents you from climbing one flight of stairs ☒ ☐

17. Home Oxygen therapy..... ☒ ☐

18. Do you drink alcohol ☒ ☐ How much per week.....

19. Problem with alcohol or drug use..... ☒ ☐

20. Hepatitis, jaundice, cirrhosis or pancreatitis (please circle)..... ☒ ☐ What and When

21. Kidney disorder - stones, infection, failure, dialysis (please circle)..... ☒ ☐ What and When

22. Organ transplant (please specify)..... ☒ ☐ When

23. Diabetes..... ☐ ☒ Treated by:
☒ diet ☐ tablets ☐ insulin

24. Stroke..... ☒ ☐ When

25. Epilepsy, fits, fainting or "funny turns" (please specify)..... ☒ ☐ What

26. Significant back injury/disorder ☐ ☒ What and When 12/02/14

27. Significant neck injury/disorder ☐ ☒ What and When 12/02/14

28. Blood disorder (leukaemia, anaemia, haemophilia or other) (please specify)..... ☒ ☐ What and When

29. Blood transfusion..... ☒ ☐ When

30. Do you object to accepting blood products for a cultural / religious reason..... ☒ ☐

31. Blood clot in legs or lungs (please circle)..... ☒ ☐ When

32. Do you have any risk factors for Creutzfeldt Jakob Disease (CJD)..... ☐ ☐ What.....

33. Does any condition prevent you from undertaking normal daily activities ☐ ☒ What Spine Problem
Headaches

34. Have you ever had any serious problems with anaesthetics or surgery before
(e.g. prolonged nausea, high temperature, prolonged drowsiness) ☒ ☐ What.....

35. Have any blood relatives had serious problems with anaesthetics ☒ ☐ What.....

36. Female patients only: Could you be pregnant? ☐ ☐ How many weeks

37. List any serious illness or medical condition (eg.Cancer, HIV, Psychiatric condition)

38. Have any of the above medical conditions become worse in the last 3 months ☐ No ☒ Yes What Spine/headache

RESPIRATORY

GENERAL

ANAESTHETIC

- FOR COMPLETION BY PATIENT -