AMBULATORY SURGERY PATIENT ASSESSMENT

BY KENYA SOCIETY OF ANAESTHESIA

TO BE COMPLETED BY ASSESSMENT STAFF

NAME:		**SURGEON:**	
AGE:		**ANAESTHETIST:**	
GENDER:		**DATE:**	
SURGERY:			

Proposed Procedure:

Blood Pressure:		Have you had any sudden unexplained weight loss	**Yes**	**No**
Pulse:				
0_2 Saturation		Are you or could you be pregnant?		
Height:		Date of LMP:		
Weight:		Contraceptive pill/implant/injection?		
BMI:		Details:		

Current Medication:

Essential criteria for day surgery admission:	**Yes**	**No**
Are you willing to undergo the proposed procedure as a day patient?		
Be able to be driven home by car or taxi?		
Have a responsible adult to take you home and stay with you for 24 hours?		
Have immediate access to a telephone?		
Have easy access to your home/toilet?		
Stay within 60 minutes drive of the hospital?		

Have you ever suffered from any of the following?	**Yes**	**No**
Chest pain on exertion or at night?		
Breathlessness or shortness of breath?		
Asthma, bronchitis, COPD or a wheeze?		
Do you or have you recently had a cough or cold?		
High Blood Pressure?		

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Heart problems, angina, heart murmur/rheumatic fever?		
Fainting easily/dizzy spells?		
Epilepsy, convulsions or fits?		
Anaemia or other blood problems e.g. Sickle Cell?		
Excessive bleeding or bruising?		
Deep vein thrombosis, pulmonary embolus or stroke?		
Kidney or urinary problems?		
Bowel problems?		
Indigestion, heartburn, hiatus hernia or stomach ulcer?		
Diabetes?		
Do You?	**Yes**	**No**
Drink more than 1.5 pints of beer or double tots of spirit per day? Approximate weekly units: [_____________________]		
Smoke: if yes how many packs/tobacco a day? [_________________]		
Take any medication or herbal remedies? [not already listed] [tablets, inhalers, creams or patches]		
Do you currently or have used recreational drugs? [Details: ____]		
Have you taken any steroids medication in the last 2 years? [Details: ____]		

Have you ever had?	**Yes**	**No**
An allergic reaction to anaesthetics, medicines, creams, elastoplasts, latex or metal? [Details: ____]		
Any other medical problem except the above? E.G. Cancer, TB, Meningitis, Thyroid, Jaundice, Hepatitis or HIV. [Details: ____]		
Muscle disease or progressive weakness?		
Arthritic or mobility problems?		
List previous operations:		

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Anaesthetic or surgical complications:	Date of last anaesthetic: [_______]
Any family history of general anaesthetic problems? Details: [____]	

Do you have any prostheses or implants?		**Yes**	**No**
Dental:			
Hearing Aid:			
Ophthalmic:			
Cardiac/ Vascular:			
Other:			

Date of investigations/blood requests:

CXR		ECG		Pregnancy Test	
FBC		Amylase		BM/Glucose	
U & E's		TFT's		Coagulation Screen	
LFT's		Calcium/Bone		INR/PIT	
Full Screen		Group & Screen		Therapeutic Drug	
Other:					

Summary of patient's health status:

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I agree that the information I have provided at the assessment to be accurate and correct.
I confirm that I have received both verbal and written information from assessment staff.
I understand that there may prolonged effects from anaesthetics which make it unsafe for me to drive, operate any form of machinery, drink alcohol or make important decisions for 24 hrs following a general anaesthetic.

Signature Patient/ Parent/ Guardian: ______________________________

Signature of Assessment Nurse: _______________________________

Date: _______________________