KINDLY COMPLETE THE FORM; INFORMATION PROVIDED WILL HELP PREPARE A SUITABLE ANAESTHETIC PLAN FOR YOUR SURGICAL PROCEDURE AND IMPROVE SAFETY

First Name:	Middle Name:	Surname:
Male: Female:	Age:	Phone number:
Email Address:	Residence/Town:	IP NO:

Surgeon Name: Signature:	Proposed Surgery:	Anaesthetist Name: Signature:

HEALTH DETAILS, (Please tick approporiately)

Do you:		
1. Smoke? ☐ YES ☐ NO	2. Drink Alcohol? ☐ YES ☐ NO	3. Use Narcortic or Recreational drugs? ☐ YES ☐ NO

Do you/have you suffered from (Please tick appropriately)								
Condition	**YES**	**NO**	**Condition**	**YES**	**NO**	**Condition**	**YES**	**NO**
Chest Pain or Tightness			Liver disease			Stroke		
Heart condition			Anemia			Seizures/Epilepsy		
High blood pressure			Persistent cough			Thyroid Disease		
Peptic ulcer/ heartburn			Asthma			Blood Clots		
Diabetes			Tuberculosis			Bleeding Disorders		
Kidney disease			Sickle Cell Disease					

If you have answered **YES** to any of the above questions, **kindly give further details:**

_____

_____

_____

_____

_____

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Do you suffer from any medical condition that is not included on the list above? **Kindly give further details**

_____

_____

_____

_____

_____

What medication (including herbal) are you currently taking?

.....

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Kindly list all surgical procedures you have undergone.

1)……. 2)…….. 3)…….... 4)…….....

Have you experienced any difficulties during any previous surgery? **YES**_____ **NO**_____
if **YES** kindly give further details.

……
…….....

Do you have any allergies? ----------

Do you have artificial lenses, healing aids or artificial cardiac prothesis, dentures, capped or loose teeth? **YES**___ **NO**___

WOMEN ONLY

Are you pregnant? **YES**___**NO**___ | When was your LMP? (Last Menstrual Period) ----------

Patient's Signature: ----------Date: ----------

TO BE COMPLETED BY THE NURSE; PATIENT VITAL SIGNS

1.Ht: _____cm | 2.Wt:_____Kg | 3.BP:____mm/Hg | 4.Pulse:_____Bpm | 5.Temp ___^{0}C | 6. Resp ____Bpm | 7. SpO_2___%

NURSE NAME ..... SIGN ..... STATION .....