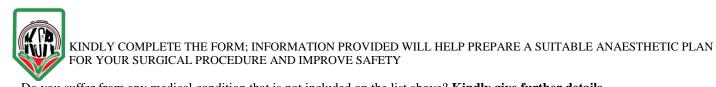


## KINDLY COMPLETE THE FORM; INFORMATION PROVIDED WILL HELP PREPARE A SUITABLE ANAESTHETIC PLAN FOR YOUR SURGICAL PROCEDURE AND IMPROVE SAFETY

First Name:			Middle Name:			Surname:				
Male: Fema	e: Female:			Age:			Phone number:			
Email Address:			Residence/Town:			IP NO:				
Surgeon Name:			Proposed Surgery:			Anaesthetist Name:				
Signature:						Signature:				
HEALTH DETAILS,	(Pleas	e tick	approporiately)							
Do you:										
1. Smoke?			2. Drink Alcohol?			3. Use Narcortic of	or Recreat	ional dı	rugs?	
YES			☐ YES			☐ YES				
□NO			□NO			□ NO				
Do you/have you suf										
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 <b>YE</b>	<b>S</b> to any	y of the	above questions, <b>kind</b>	ly give fu	urther	details:			- -	



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?
Kindly list all surgical procedures you have undergone.
1)
Have you experienced any difficulties during any previous surgery? <b>YES NO</b> if <b>YES</b> 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
<u>WOMEN ONLY</u>
Are you pregnant? YESNO   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.Temp0C   6. RespBpm   7. SpO <sub>2</sub> %
NURSE NAME SIGN STATION