PRE-ANAESTHETIC FORM

*** PLEASE COMPLETE AND RETURN: (Circle "No" or "Yes" as appropriate)

Note: This Form is for the use of your Anaesthetist - it is NOT a Consent Form.

NAME: ______________________________

(last name) (first names) (maiden name) (alternate last names)

(1) Have you had any previous operations: No **(Yes)**

Year	Operation	Hospital
1994	Dental	OSMH

(2) (a) Have you had an anaesthetic as an in- or out-patient? YEAR: 1994 — No **(Yes)**

(b) Have you had any complications from an anaesthetic? **(No)** Yes

(c) Have any members of your family had a bad reaction to one? **(No)** Yes

(3) Have you ever had any of the following diseases? **(No)** Yes

Heart Attack; Heart Disease; Rheumatic Fever; High Blood Pressure; Asthma; Chronic Bronchitis; Tuberculosis; Arthritis; Jaundice; Diabetes; Thyroid Disease; Kidney Disease; Mental or Nervous Disease.

(4) Do you have any other disease which periodically requires treatment? No **(Yes)**

Name: See enclosed

(5) Do you get short of breath or tightness in your chest if you:

Walk one block; do your housework and gardening; climb one flight of stairs. **(No)** Yes

(6) Do you smoke? If "Yes", how much ______ **(No)** Yes

(7) Have you had a cough or cold within the last month? **(No)** Yes

(8) Do you take any pills or medicines regularly? No **(Yes)**

* Name: See enclosed

(9) Are you, or have you been, a drug user ((alcohol; street drugs or other related drugs)? **(No)** Yes

(10) Do you have any allergies? **(No)** Yes

Name: none Known

(11) Do you have "loose" teeth; "capped" teeth: dentures or fixed bridge work? **(No)** Yes

(12) If female - are you pregnant? **(No)** Yes

(13) Within the last year, have you taken any medicine or pills for: Rheumatism; Arthritis or Allergies? e.g. Cortisone or Prednisone. **(No)** Yes

* PLEASE NOTE! If you take regular medicine, take on day of surgery with minimum of water or contact doctor.

DATE: July 24/96 SIGNATURE: ______

RELATIONSHIP TO PATIENT: [handwritten signature]

** PLEASE USE BACK OF FORM IF NECESSARY.

D-97

CB

Cottage 10

PRE-ANAESTHETIC FORM

*** PLEASE COMPLETE AND RETURN: (Circle "No" or "Yes" as appropriate)

Note: This Form is for the use of your Anaesthetist - it is NOT a Consent Form.

NAME: [redacted]

(last name) (first names) (maiden name) (alternate last names)

(1) Have you had any previous operations: **No** Yes

Year	Operation	Hospital

(2) (a) Have you had an anaesthetic as an in- or out-patient? YEAR: **No** Yes

(b) Have you had any complications from an anaesthetic? **No** Yes

(c) Have any members of your family had a bad reaction to one? **No** Yes

(3) Have you ever had any of the following diseases? **No** Yes

Heart Attack; Heart Disease; Rheumatic Fever; High Blood Pressure; Asthma; Chronic Bronchitis; Tuberculosis; Arthritis; Jaundice; Diabetes; Thyroid Disease; Kidney Disease; Mental or Nervous Disease.

(4) Do you have any other disease which periodically requires treatment? No **Yes**

Name: See enclosed.

(5) Do you get short of breath or tightness in your chest if you:

Walk one block; do your housework and gardening; climb one flight of stairs. **No** Yes

(6) Do you smoke? If "Yes", how much **No** Yes

(7) Have you had a cough or cold within the last month? **No** Yes

(8) Do you take any pills or medicines regularly? No **Yes**

* Name: See enclosed

(9) Are you, or have you been, a drug user ((alcohol; street drugs or other related drugs)? **No** Yes

(10) Do you have any allergies? **No** Yes

Name: none known

(11) Do you have "loose" teeth; "capped" teeth; dentures or fixed bridge work? **No** Yes

(12) If female - are you pregnant? **No** Yes

(13) Within the last year, have you taken any medicine or pills for: Rheumatism; Arthritis or Allergies? e.g. Cortisone or Prednisone. **No** Yes

* PLEASE NOTE! If you take regular medicine, take on day of surgery with minimum of water or contact doctor.

DATE: March 4/94 SIGNATURE [redacted]

RELATIONSHIP TO PATIENT: Nurse Case Manager

** PLEASE USE BACK OF FORM IF NECESSARY.

D-97