THE SURGICAL INSTITUTE

Name: ID Number: Age:

Height: Weight:

In Case of Emergency Contact Name: Number:

Medical Aid: Medical Aid Number: House Doctor:

Cardiologist / Other Specialist if Applicable: Allergies:

To Be Completed By Patient/Parent/Guardian/Anaesthetist

	Please don't drive within 24 hours after anaesthesia	No	Yes	Details Of Condition Or Doctor Whom To Contact
	Cardiac Diseases, High Blood Pressure, Rheumatic Fever, Congenital Heart Disease			
	Asthma, Bronchitis, Emphysema Or Any Other Lung Disease			
	Cough Or Cold			
	Jaundice Or Other Liver Disease			
	Digestive Tract Disease			
	Kidney Diseases			
	Diabetes Mellilus (Include Medication)			
	Arthritis, Osteoporosis, Rheumatism			
	Epilepsy / Stroke (Includes Medication)			
	Thyroid Problems (Includes Medication)			
	Muscular Diseases			
	Porphyria (Include Family History)			
	Bleeding Tendancy (Include Family History)			
	Neurological Diseases (E.G Alzheimers, Parkinsons)			
	Smoking (Daily Amount)			
	Alcohol (Average Daily Consumption)			
	Previous Operations (Dates Also)			
	Complications Or Unusual Reactions By Patient Or Family Member To General Or Local Anaesthetic (E.G Malignant , Hyperthermia, Vomiting)			
	Cardiac Drugs			
	Cortisones Or Other Steroids			
	Blood Pressure Drugs			
	Anti-Coagulants, Aspirin, Warfarin			
	Sedatives, Sleeping Tablets Or Anti-Depressant Drugs			
	Other Drugs (E.G Homeopathic/Herbal/Vitamins)			
	Travel History			
	Dentures (Crowns, Bridge, Loose Teeth)			
	Prosthesis (E.G Hip Replacement)			
	Contact Lenses			
	Pregnant			
	Last Intake Of Food/Liquid			Date Time

Patient Signature: Date:

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