Pre-Op Health Questionnaire – Dr Kim

Please fill in the following questionnaire to assist Dr Kim in preparing for your operation.

The hospital will commonly have you complete a similar questionnaire prior to your admission for their own records - this is usually not provided to Dr Kim. To ensure Dr Kim is properly prepared for your anaesthetic, please complete this questionnaire to the best of your ability.

This form is BEST completed online at www.drorisonkim.com.au - Please only complete this PDF form if you do not have access to a computer and internet.

To enable you to complete your questionnaire as quickly as possible, please have on hand:
- Your health care cards (Medicare card, private fund card etc)
- Contact details of your usual Doctors (GP & Specialists)
- Details of your current medications
- A scanned PDF or JPG of any results or letters you wish to send your Anaesthetist

* Denotes a required field

Patient Details:

Patient's Name *

First

Last

Gender *

- [x] Male
- [x] Female

Is this you? *

- [ ] Yes
- [ ] No

If this is not you, please list your name and relationship to the patient

Phone Number(s) *

Email

Patient's Age *

(in years - if a child, please use a decimal if desired, eg. 2years 6months = 2.5)

Operation Details:

Surgeon *

Hospital

Operation *

(the procedure being performed)

Date of Operation

Why are you having this operation?

(what symptoms or diagnosis made you to decide to undergo this procedure?)

Patient Details:

Height (cm)

Weight (kg) *

Have you or any blood relatives ever had any problems with anaesthetics in the past? *

- Yes
- No

If yes, please provide details

Details of previous anaesthetics

(if you can remember when and in what hospitals you previously underwent an anaesthetic, providing these details can help in retrieving previous anaesthetic records meaning past problems could potentially be avoided)

Do you have any allergies? *

(especially to medications including antibiotics, latex products, foods or iodine)

- Yes
- No

If yes, what are you allergic to and what is the reaction?

Do you take regular medications? *

(this includes all tablets, puffers, patches, sprays, injections, eye drops etc.)

- Yes
- No

If yes, please detail each medication with the amount taken and how often you take it

Do you have, or have you ever had, any of the following?

Any trouble with your heart or cardiovascular system? *

(this could include high blood pressure, chest pains, angina, heart attacks, coronary artery stents, coronary artery bypass surgery, heart rhythm problems, having a pacemaker or defibrillator, strokes or mini strokes)

- Yes
- No

If yes, please provide details (make sure you include your Cardiologist's name and contact details if applicable)

Shortness of breath climbing less than 2 flights of stairs or whilst walking for 30 minutes on flat ground? *

- Yes
- No

Any trouble with your lungs or respiratory system? *

(this could include asthma, obstructive sleep apnoea (OSA) with or without CPAP mask use, or smoking-related problems)

- Yes

- [ ] No

If yes, please provide details (make sure you include your Respiratory or Sleep Doctor's name and contact details if applicable)

Diabetes? *

- [ ] Yes
- [ ] No

If yes, how is your diabetes treated?

(select all that apply)

- [ ] Insulin
- [ ] Tablets
- [ ] Diet

If you use insulin, at what blood glucose level (BGL) would you start to get symptoms of a 'hypo'?

(only if this is known, ie. your anaesthetist needs to maintain your BGL above this value whilst you undergo your procedure)

Gastro-oesophageal reflux disease (GORD), gastritis, oesophagitis, stomach or duodenal ulcers, hiatus hernia? *

- [ ] Yes
- [ ] No

If yes, please select the following which apply

(multiple options can be selected)

- [ ] When bending forward or lying flat you get a burning sensation or acid rising into your mouth or throat, or you get this same sensation waking you from sleep
- [ ] You previously suffered from this burning sensation or acid rising into your mouth or throat, but since commencing treatement this no longer occurs
- [ ] You don't get this acid rising sensation, but you do suffer from stomach/abdominal discomfort or burning
- [ ] You previously suffered from this stomach/abdominal discomfort or burning, but since commencing treatment this no longer occurs

Thyroid disease? *

- ○ Yes
- ○ No

If yes, please select the following which apply

- ☐ Your thyroid hormone levels are normal
- ☐ Your last blood test was within 12 months
- ☐ Your breathing becomes difficult when lying flat
- ☐ You are unsure on your current thyroid disease status

Do you have an enlarged thyroid gland, otherwise called a goitre?

- ○ Yes
- ○ No

If you have Thyroid disease please list your Endocrinologist's name and contact details

Kidney condition? *

- ○ Yes
- ○ No

If yes, please provide details (make sure you include your Nephrologist, Kidney or Dialysis Doctor's name and contact details if applicable)

Blood clots or excessive bleeding? *

(eg. deep vein thrombosis (DVT), pulmonary embolism (PE), haemophilia, and others)

- ○ Yes
- ○ No

If yes, please provide details (make sure you include your Haematologist or Blood Doctor's name and contact details if applicable)

With regards to your teeth or dentition - what do you have? *

(please select all that apply)

- [ ] Loose tooth or teeth
- [ ] Chipped tooth or teeth
- [ ] Caps, crowns, or veneers
- [ ] Implant(s)
- [ ] Bridge(s)
- [ ] Partial upper dentures
- [ ] Partial lower dentures
- [ ] Full upper dentures
- [ ] Full lower dentures
- [ ] Your own teeth +/- fillings only

Please indicate the pain relievers or analgesics that have worked well for you previously *

- [ ] Paracetamol, eg. Panadol
- [ ] Anti-inflammatories, eg. Nurofen, Voltaren, Celebrex, Mobic
- [ ] Tramadol, eg. Tramal
- [ ] Paracetamol-codeine combinations, eg. Panadeine Forte, Painstop
- [ ] Strong opioids, eg. OxyNorm, Endone, Targin, Sevredol
- [ ] None of the above
- [ ] Other

Please indicate the pain relievers or analgesics that you must avoid or should not use *

- [ ] Paracetamol, eg. Panadol
- [ ] Anti-inflammatories, eg. Nurofen, Voltaren, Celebrex, Mobic
- [ ] Tramadol, eg. Tramal
- [ ] Paracetamol-codeine combinations, eg. Panadeine Forte, Painstop
- [ ] Strong opioids, eg. OxyNorm, Endone, Targin, Sevredol
- [ ] Other
- [ ] I am not aware of any pain relievers or analgesics that I must avoid or should not

use

Any other health issues you wish to mention? *

- ○ Yes
- ○ No

If yes, please provide details

Upload medical information

(please feel free to upload any medical reports, test results, Specialist letters or supporting information)

Browse... No file selected. Accepted file types: jpg, gif, png, pdf, doc, docx.

Other Details:

Do you have someone to collect you from hospital and who can help you for the first 24 hours after discharge? *

- ○ Yes
- ○ No

Name and telephone numbers of your doctors

(GPs and Specialists)

Do you give your consent for me to contact your other doctors if required? *

(to provide you with the safest anaesthetic Dr Kim may need to contact your other doctors to obtain test results, specialist letters, or other information. This allows better understanding of your health, meaning your anaesthetic can be individualised appropriately)

- ○ Yes
- ○ No

Are you entitled to access Medicare rebates by the Australian Government? *

(ie. do you have a green Medicare card?)

- ○ Yes
- ○ No

Do you have private health insurance? *

- ○ Yes
- ○ No

If yes, to which health fund do you belong and what is your member number?

Would you like an estimate of the Anaesthetic Fee pre-operatively? *

- ○ Yes
- ○ No - I am happy to proceed as is

Preferred method to pay Anaesthetic Fee? *

- ○ Credit Card
- ○ Cash
- ○ Direct Deposit (eg. via an internet funds transfer)
- ○ Workers Compensation or Defence Force account
- ○ Other

Dr Kim will receive all the information submitted via this questionnaire. Depending upon your answers, Dr Kim may decide to contact you to obtain more information, or simply to discuss particular aspects of the anaesthetic. Alternatively, Dr Kim may be satisfied with the information submitted and be ready to proceed with your anaesthetic as is.

Would you like to receive a phone call from your anaesthetist prior to your procedure? *

- ○ Yes
- ○ Only if my anaesthetist has specific issues they wish to discuss
- ○ I'm not fussed
- ○ No

By submitting this form you confirm the information provided is true and correct to the best of your knowledge and can be relied upon by your anaesthetist in making clinical decisions.

Is there anything else you would like to mention? *

- ○ Yes
- ○ No

If yes, please provide details

Signature (sign or write Authorised)

Please save this form & upload it via a message at drorisonkim.com.au