PREOPERATIVE SEDATION QUESTIONAIRE **Victorian Oral and Facial Surgeons**

It is important that you speak to your doctor about when you should stop eating and drinking before your anaesthetic.

The Anaesthetist will also need to know the following:

- Any recent coughs, colds or fevers and COVID test result
- Any previous anaesthetics or family problems with anaesthesia
- Abnormal reactions or allergies to drugs
- Any history of Obstructive Sleep Apnoea, asthma, bronchitis, heart problems or other medical problems
- Any medications you may be taking

The form below must be completed and returned to the Surgeon at least 24 hours prior to your surgery in order to proceed with your operation.

Patient Name:_____ **Date of Surgery:**_____

Your surgeon: ☐ **Mr Verco** ☐ **Mr Woods** ☐ **Mr Savage**

What is your age?		Years
What is your height?		Cm
What is your weight?		Kg
Do you have any allergies or alerts? Details:	Yes	No
Have you had problems with your lungs, asthma or obstructive sleep apnoea? Details:	Yes	No
Do you use a CPAP machine?	Yes	No
Have you had any problems with your heart or blood pressure? Details:	Yes	No
Do you have a pacemaker or artificial heart valve?	Yes	No
Do you have diabetes?	Yes	No
Have you had any problems with your liver?	Yes	No
Do you have a kidney disease?	Yes	No
Have you had any other serious illnesses?	Yes	No
Do you have a history of any bleeding tendencies?	Yes	No
Have you had an anaesthetic? What was the procedure?	Yes	No
Were there any complications with the surgery or anaesthetic? Details:	Yes	No
Are you taking any medicines or tablets? If yes, please specify:	Yes	No
Do you drink alcohol or use recreational drugs? Details:	Yes	No
Do you or have you recently had any type of infection?	Yes	No
Have you recently travelled overseas? Where did you travel?	Yes	No
Have you been exposed to any infectious diseases? (i.e. COVID 19, Hepatitis, HIV, Mad Cow, SARS)	Yes	No
Have you recently taken Aspirin or other blood thining medication? Please circle: *Pradaxa/Clopidagrel/Warfarin/Anti-inflammatory drugs* Last Dose taken:	Yes	No
Do you smoke? If yes, how many per day? When did you quit?	Yes	No
Do you have any physical disabilities?	Yes	No
Could you be pregnant? Last menstrual period:	Yes	No
Have you had two or more accidental falls in the past 12 months?	Yes	No
Do you have an Advanced Care Plan and other treatment-limiting orders? Details:	Yes	No
Do you have a hearing aid, prosthesis, contact lenses or body piercing?	Yes	No
Do you have any loose teeth, caps or crowns?	Yes	No
Have you had recent pathology tests? Laboratory name:	Yes	No
Have you had recent X-rays or an ECG? Facility name:	Yes	No
Do you have a responsible adult to accompany you home?	Yes	No
Do you have a responsible person to stay with you at home, at least overnight, following your discharge from the surgical procedure and sedation?	Yes	No

Office use only

Referred to Anaesthetist:_____ Date:_____