medical assessment form / dental procedure

ANAESTHETIC GROUP BALLARAT

Please fill in the following details and return to the Anaesthetic Group with your Patient details and consent form. This information will assist your anaesthetist in preparing for your anaesthetic.
All information will be kept confidential.

Patient details

Title	Surname	Given Name(s)

Dentist/Surgeon's Name	Date of Procedure

Hospital

Home Phone	Work Phone	Mobile

Date of Birth	Age

Parent/Guardian Name (If the patient is under 18 years old)	Date

1. Have you ever had a serious medical problem (e.g. asthma, diabetes, bleeding disorder, stroke)? YES / NO
   If yes, please specify

2. Are you on any medication? YES / NO
   If yes, please specify

3. Have you ever had any problems with anaesthetics before? YES / NO
   If yes, please specify

Signed by Patient/Parent/Guardian	Date

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