CAPE SEDATION

Patient information

Title

Last name

First name

Date of birth

I.D number

Occupation

Account details (person responsible for the account)

Last name

First name

I.D number

Employer

Home address

Postal address

Telephone (Home)

Telephone (Work)

Telephone(Mobile)

Email address

Medical Aid Details (for account purposes only)

Medical Aid Scheme

Medical Aid Plan

Name Of Main Member

Main Member I.D number

Medical Aid Number

Patient Dependant Code

Authorisation Number

Medical Questionnaire

Last name | First name

Age | Sex | Height (cm) | Weight (kg)

Female | Male

Anaesthesia / Sedation

	Yes	No
Have you ever had any adverse or unpleasant reaction to anaesthesia or sedation?		
Have you had a failed sedation (cancelled due to difficulty?		

If any answer is "yes", please provide a detailed explanation below.

Cardiovascular disease

	Yes	No
Do you suffer from heart failure, ischemic heart disease e.g. angina, heart attack?		
Do you suffer from heart valve lesion, rheumatic fever, congenital heart disease?		
Do you suffer from dysrythmia, palpitations (without exertion), blackouts?		
Do you become short of breath when lying down or walking on a level surface?		
Do you suffer from high blood pressure?		
If "yes" whats was your last blood pressure reading?		

If any answer is "yes", please provide a detailed explanation below.

Central Nervous System disorders

	Yes	No
Do you suffer from epilepsy, fits (convulsions), giddiness?		
Do you suffer from depression, psychosis?		
Have you had a stroke?		
Do you suffer from Autism?		
Do you suffer from ADHD, Hyperactivity?		

If any answer is "yes", please provide a detailed explanation below.

Blood clots

	Yes	No
Have you had thrombosis, embolism in the legs or lung?		

If answer is "yes", please provide a detailed explanation below.

Blood disorders

	Yes	No
Do you suffer from anaemia, sickle cell disorder, thalasaemia, etc.?	☐	☐
Have you had abnormal bleeding associated with previous extractions, surgery or trauma and do you bruise easily?	☐	☐

If any answer is "yes", please provide a detailed explanation below.

Respiratory

	Yes	No
Do you smoke? If "yes" how many a day?	☐	☐
Do you snore and or have sleep Apnoea?	☐	☐
Do you suffer from lung disease (e.g. asthma, emphysema, TB)?	☐	☐
Have you had Flu or chest infection in the last 4 weeks?	☐	☐

If any answer is "yes", please provide a detailed explanation below.

Endocrine disorders

	Yes	No
Do you suffer from thyroid problems?	☐	☐
Do you suffer from porphyria or other metabolic disorders?	☐	☐
Do you suffer from diabetes?	☐	☐
Latest blood sugar reading?		

If any answer is "yes", please provide a detailed explanation below.

Liver

	Yes	No
Do you suffer from hepatitis or have a history of jaundice or any other liver disease?	☐	☐
Do you drink alcohol?	☐	☐

If “Yes” how much per day/week?

If any answer is "yes", please provide a detailed explanation below.

Renal

	Yes	No
Do you suffer from kidney disease / renal failure?	☐	☐

If answer is "yes", please provide a detailed explanation below.

Muscular disorder

Yes No

Do you suffer from myopathy, dystrophy or progressive weakness? ☐ ☐

If answer is "yes", please provide a detailed explanation below.

Orthopeadic problems

Yes No

Do you suffer from arthritis? ☐ ☐

Do you suffer from lower back problems? ☐ ☐

Do you suffer from decreased neck mobility? ☐ ☐

Do you suffer from decreased mouth opening? ☐ ☐

If any answer is "yes", please provide a detailed explanation below.

Stomach problems

Yes No

Do you suffer from indigestion, heartburn, hernia or ulcers? ☐ ☐

If answer is "yes", please provide a detailed explanation below.

Hereditary diseases

Yes No

Are there any hereditary diseases in your family? ☐ ☐

If answer is "yes", please provide a detailed explanation below.

Hospitalisations and Operations

Yes No

Have you ever been admitted to hospital? ☐ ☐

If answer is "yes", please provide a detailed explanation below.

History of allergy in general, or allergic reactions to medications

Yes No

Do you suffer from allergies (especially and allergy to medication)? ☐ ☐

If answer is "yes", please provide a detailed explanation below.

Yes No

Medication

Do you take any regular medication (drugs), including herbal and recreational drugs?

If answer is "yes", please provide a detailed explanation below.

Yes No

Infectious Disease

Do you suffer from any infectious disease (HIV, Hepatitis)?

If answer is "yes", please provide a detailed explanation below.

Others

If there is anything you would like to discuss but prefer not to submit here please contact your seditionist and speak to him/her before the date of your procedure.

Designated Driver who will take patient home

Name

Telephone number