DR STEPHAN KLEYN

SPECIALIST ANAESTHESIOLOGIST

MBChB (Stell) | DA (SA) | FCA (SA) | MMed (Anaes) (UCT)

PLACE PATIENT STICKER HERE

071 286 8119 | kleynstephan@gmail.com | Cape Town, South Africa

MEDICAL QUESTIONNAIRE

PATIENT DETAILS

Full names and surname: _____ Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr

ID Number: | | | | | | | | | | | | | | |

PERSON RESPONSIBLE FOR THE ACCOUNT (IF NOT THE PATIENT)

Full names and surname: _____ Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr

ID Number: | | | | | | | | | | | | | | |

Occupation:	Name of business or employer:
Postal address:	Residential address:
Medical aid:	Medical aid number:

Plan:	Gap cover: ☐ Yes ☐ No	Gap cover provider:
Email:		Tel (Home):
Cell:		Tel (Work):

MEDICAL QUESTIONNAIRE

Age:	Weight (kg):	Height (cm):	Pregnant or breastfeeding: ☐ Yes ☐ No
Smoking or e-cigarette use: ☐ Yes ☐ No	Amount per day:	Alcohol use per week:	

Allergies / unusual reaction to medicines (which?):

Current Medication (please list):

Previous Anaesthetics – when and for what?

Anaesthetic problems, or family member with anaesthetic problems?

HAS THE PATIENT EVER HAD PROBLEMS WITH THE FOLLOWING?

High blood pressure ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Asthma / Emphysema ☐ Yes ☐ No
Heart disease ☐ Yes ☐ No	Thyroid ☐ Yes ☐ No	Bladder / Kidney disease ☐ Yes ☐ No
Stroke / TIA / Blackouts ☐ Yes ☐ No	Epilepsy ☐ Yes ☐ No	Muscle disease ☐ Yes ☐ No
Heartburn or reflux ☐ Yes ☐ No	Recent cold / Flu ☐ Yes ☐ No	Blood thinner medications ☐ Yes ☐ No
False, loose, crowns or chipped teeth ☐ Yes ☐ No	Implanted pacemaker or defibrillator ☐ Yes ☐ No	Scoline apnoea, porphyria or malignant hyperthermia ☐ Yes ☐ No

Anything else you would like to tell your anaesthetist?

_____

_____

_____

IMPORTANT: Please ensure all relevant medical information is disclosed to your anaesthetist. Withholding information may increase the risks associated with anaesthesia.