

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	Given Name(s)	Surname	
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