

Pre operative Assessment Form

Form no. 1		Left Pain Right		Left Size Right	
Patients Number		<input type="checkbox"/> Mild		<input type="checkbox"/> Inguinal Canal	
Patient's Surname		<input type="checkbox"/> Nil		<input type="checkbox"/> Superficial Ring	
Patient's Given Name		<input type="checkbox"/> Severe		<input type="checkbox"/> Inguinal Scrotal	
Date of Birth		Left Reducible Right		Site Left	
Address		<input type="checkbox"/> Easily		<input type="checkbox"/> Inguinal	
Hospital		<input type="checkbox"/> With Difficulty		<input type="checkbox"/> Recurrent	
<input type="checkbox"/> Holroyd Private Hospital		<input type="checkbox"/> Irreducible		<input type="checkbox"/> Other	
<input type="checkbox"/> Other		Occupation		Site Right	
Insurance Category		<input type="checkbox"/> Home Duties		<input type="checkbox"/> Inguinal	
<input type="checkbox"/> Private Insurance		<input type="checkbox"/> Manual/Significant sport activity		<input type="checkbox"/> Recurrent	
<input type="checkbox"/> Work Cover		<input type="checkbox"/> Retired		<input type="checkbox"/> Other	
<input type="checkbox"/> Self Insured		<input type="checkbox"/> Sedentary		Site Bilateral	
<input type="checkbox"/> Other		<input type="checkbox"/> Self Employed		<input type="checkbox"/> Inguinal	
General Health		Smoker		<input type="checkbox"/> Recurrent	
<input type="checkbox"/> 1. A Normal Healthy Patient		<input type="checkbox"/> <10 per day		<input type="checkbox"/> Other	
<input type="checkbox"/> 2. A patient with Mild Systemic Disease.		<input type="checkbox"/> >10 per day		Femoral Hernia	
<input type="checkbox"/> 3. A patient with severe systemic disease that limits activity but is not incapacitating.		<input type="checkbox"/> Nil		<input type="checkbox"/> Left	
<input type="checkbox"/> 4. A patient with an incapacitating systemic disease that is a constant threat to life		Left Noticed Groin Pain Right		<input type="checkbox"/> Right	
<input type="checkbox"/> 5. A moribund patient not expected to survive 24 hours with or without operation		<input type="checkbox"/> <1 Years		<input type="checkbox"/> Bilateral	
<input type="checkbox"/> 6. Emergency		<input type="checkbox"/> >2 Years		Other Relevant Information	
		<input type="checkbox"/> 1 Year			
		<input type="checkbox"/> 2 Years			