St. Joseph's Healthcare Hamilton

Patient Questionnaire
Department of Anaesthesia

Name: _____

Surgery: _____ Age: _____

A. General

	Yes	No
• Have you ever had anaesthesia?	☐	☐
• Have you or a relative had any problems with anaesthesia such as unusual temperature changes, trouble breathing, etc?	☐	☐
• List past surgeries:		
• Do you smoke?	☐	☐
• Number of cigarettes a day ____ Number of years ____		
• Do you drink alcohol?	☐	☐
• Number of drinks a week	☐	☐
• Do you use recreational or street drugs?	☐	☐
• Have you taken cortisone, prednisone or ACTH within the last year?	☐	☐
• Have you ever been treated for cancer?	☐	☐
• Could you be pregnant? ____ Last menstrual period: _____	☐	☐
• Do you have capped or loose teeth, partial or full dentures?	☐	☐

B. Respiratory

• Have you had a cold, flu or chest infection in the last month?	☐	☐
• Do you have any trouble with your breathing?	☐	☐
• Do you have a cough with mucous, sputum or phlegm?	☐	☐
• Have you ever been diagnosed with a significant respiratory condition such as asthma, tuberculosis, emphysema, chronic bronchitis or SARS?	☐	☐
• Do you have sleep apnea, excessive snoring or use home oxygen?	☐	☐
• Are you on C-PAP or Bi-Pap at home?	☐	☐

C. Cardiovascular

• Do you have high blood pressure?	☐	☐
• Have you ever had a heart attack?	☐	☐
• Have you ever had angina, chest pain or irregular heart beat?	☐	☐
• Do you have a heart murmur?	☐	☐
• Have you ever had heart failure?	☐	☐
• Can you walk two blocks without stopping?	☐	☐
• Do you have problems with circulation to the legs?	☐	☐

Please turn over →