St. Joseph's Healthcare Hamilton

PRE-ANESTHETIC PATIENT QUESTIONNAIRE

Date (yyyy/mm/dd) :_____

Patient name:_____Age: _____

Surgery: _____

Name of person completing this form:_____

Relationship to patient: _____

PLACE PATIENT ID LABEL HERE

A. General	Yes	No
■ Have you ever had anesthesia? ☐ Spinal/Epidural ☐ General • Surgeries and dates: _____ _____ _____	☐	☐
■ Have you or a relative had any problems with anesthesia, such as malignant hyperthermia, breathing problems or difficulty with insertion of the anesthesia breathing tube? _____ _____	☐	☐
■ Do you smoke? • Number of cigarettes a day:_____ Number of years:_____	☐	☐
■ If you have ever smoked? • When did you stop smoking?: _____		
■ Do you drink alcohol? • Number of drinks a week: _____	☐	☐
■ Do you use recreational or street drugs or marijuana? • Type:_____ Amount: _____ How often: _____	☐	☐
■ Have you taken cortisone, prednisone or other steroids in the last 3 months?	☐	☐
■ Have you ever been treated for cancer? Type:_____ When: _____	☐	☐
■ Could you be pregnant?	☐	☐
■ Do you have capped or loose teeth, partial or full dentures or veneers?	☐	☐

B. Respiratory	Yes	No
■ Have you had a cold, flu or chest infection in the last month?	☐	☐
■ Do you have a cough with sputum?	☐	☐
■ Do you have any trouble with your breathing?	☐	☐
■ Have you ever been diagnosed with: ☐ asthma ☐ tuberculosis ☐ emphysema ☐ COPD	☐	☐
■ Do you use home oxygen?	☐	☐
■ Do you have a Respirologist? Name: _____	☐	☐
■ Do you have excessive snoring or sleep apnea?	☐	☐
■ Is your sleep apnea treated with: ☐ C-PAP or ☐ Bi-Pap? What are the settings?: _____	☐	☐

C. Cardiovascular	Yes	No
■ Do you have high blood pressure?	☐	☐
■ Have you ever had: ☐ angina ☐ heart attack ☐ cardiac surgery ☐ carotid surgery	☐	☐
■ Do you have an irregular heart beat?	☐	☐
■ Do you have a: ☐ pacemaker ☐ defibrillator	☐	☐
■ Do you have a heart murmur?	☐	☐
■ Have you ever had heart failure?	☐	☐
■ Do you have a Cardiologist? Name: _____	☐	☐
■ Can you walk two blocks without stopping?	☐	☐
■ Do you have problems with circulation in the legs (peripheral vascular disease)?	☐	☐
■ Have you ever had a stroke or TIA? When? _____	☐	☐

D. Gastrointestinal	Yes	No
■ Have you ever had liver problems such as hepatitis?	☐	☐
■ Do you have frequent heartburn, ulcers or hiatus hernia?	☐	☐

St. Joseph's Healthcare Hamilton

PRE-ANESTHETIC PATIENT QUESTIONNAIRE

PLACE PATIENT ID LABEL HERE

E. Renal	Yes	No
■ Have you ever had kidney disease?	☐	☐
■ Are you a dialysis patient? ☐ Peritoneal ☐ Hemodialysis	☐	☐

F. Endocrine	Yes	No
■ Do you have diabetes?	☐	☐
• How is your diabetes managed? ☐ Diet ☐ Oral medication ☐ Insulin		
■ Do you have thyroid problems?	☐	☐

G. Neurological/Musculoskeletal	Yes	No
■ Have you ever had seizures? If yes, when was your last seizure? _____	☐	☐
■ Have you ever had a stroke? When? _____	☐	☐
■ Do you have any neurological or muscle disorders? Type: _____	☐	☐
■ Do you have arthritis? ☐ osteoarthritis ☐ rheumatoid arthritis ☐ other:	☐	☐
■ Have you ever been treated for a psychiatric illness? Type: _____	☐	☐

H. Hematological	Yes	No
■ Have you ever been diagnosed with a bleeding disorder?	☐	☐
■ Are you anemic?	☐	☐
■ Have you ever had a blood clot in your legs or lungs?	☐	☐
■ Do you have ☐ thalassemia ☐ sickle cell disease	☐	☐
■ Have you taken a blood thinner in the last month? Type: _____	☐	☐
• When did you stop taking the blood thinner? _____		
• Will you accept blood products if necessary?	☐	☐

I. Allergies and Medications

■ Are you allergic to latex? Yes ☐ No ☐ Type of reaction:_____

List all allergies:	Type of reaction:
_____	_____
_____	_____
_____	_____

List all medications (include over the counter medicine, inhalers, patches, drops , vitamins, minerals, supplements, herbs):

Medication name	Dose	How often	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

J. Is there anything we need to know about you to help make your hospital stay the best possible experience for you?

Clinic use only BP- L or R HR- RR- O2 Sats- T- Pain/location-

Data validated by: Printed Name :_____ Signature:_____ Designation:_____Date:_____