

**PRE-ANESTHETIC PATIENT QUESTIONNAIRE**

**Department of Anesthesia**

Patient's name	Date <small>year / month / day</small>		
What name would you like to be addressed by?	Wt.	Ht.	Sex Age
Surgeon	Date of Surgery <small>year / month / day</small>		

**The questions which follow relate to your anesthetic. Please take time to consider them carefully since your answers will be of considerable help to your anesthesiologist and may be very important for your safety. Please answer by checking YES or NO or DON'T KNOW.**

QUESTION	YES	NO	Don't Know
1. Are you taking any medications? (List on reverse. Please include non-prescription drugs and herbal remedies)			
Do you have allergies to medication or environmental exposures? (List on reverse)			
2. Are there any medications you MUST NOT take? (List on reverse)			
3. Do you have, or have you had any form of heart disease?			
4. Do you have, or have you had recurrent chest pain or angina?			
5. Are your daily activities limited by shortness of breath?			
6. Do you have, or have you had any form of high blood pressure?			
7. Are you taking fluid pills or water pills regularly?			
8. Do you smoke? How many/day? If you smoked in the past, when did you quit? _____			
9. Do you have any lung disease, eg. asthma, bronchitis, cough with sputum?			
10. Do you snore? Have you ever been told you have sleep apnea?			
11. Have you ever had jaundice, hepatitis, or liver disease?			
12. Have you ever had nephritis or kidney disease?			
13. Do you have, or have you had diabetes?			
14. Do you have a hiatus hernia/regurgitation of food or reflux of stomach acid?			
15. Do you suffer from motion sickness?			
16. Have you been treated with steroids within the past 6 months (cortisone, prednisone, etc.)?			
17. Have you ever had chemotherapy/radiotherapy?			
18. Do you bleed excessively from tooth extractions or other wounds?			
19. Have you ever had a blood transfusion?			
20. Do you have, or have you had disease, injury or deformity to your back, neck, spine or joints?			
21. Do you have, or have you had weakness of your arms or legs?			
22. Have you loose, capped, bonded, veneered teeth, dentures or bridge work?			
23. Have you had any operations? (List on reverse)			
24. Approximately how long is it since your last anesthetic?			

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**Please complete in Black Ink**

QUESTION	YES	NO	Don't Know
25. Have you ever had a spinal or epidural anesthetic?			
26. If your anesthetic is within the next few hours, when did you last have anything to eat or drink? _____			
27. If female and of childbearing age, is there any possibility that you are pregnant?			
28. Have you recently been exposed to chicken pox, measles or mumps?			
29. If you could possibly be carrying the AIDS or HEPATITIS B virus, please notify your anesthesiologist on the day of surgery.			

MEDICATIONS YOU ARE TAKING REGULARLY			OPERATIONS YOU HAVE HAD AND APPROXIMATE DATES	OTHER SERIOUS MEDICAL PROBLEMS OR ALLERGIES
Name	Dose	Frequency		

**The Department of Anesthesia advises cigarette smokers to reduce and preferably stop smoking for two to three weeks before surgery and anesthesia. In particular, there should be *absolutely no smoking for at least eight (8) hours prior to proposed anesthesia.***

Patient's signature

Date

If you have any further questions, call the Anaesthesia Associates  
**(519) 744-7361**, Monday to Friday, 9:00 a.m. to 4:00 p.m.