niagarahealth

Extraordinary Caring. Every Person. Every Time.

Anaesthetic Patient Questionnaire

Name: _____ Surgeon: _____ Date of Surgery: _____

Name you would like to be called: _____

Name of person completing this form (if not the patient): _____

Relationship: _____

Allergies: _____

Instructions: Please read all questions carefully and respond by checking (√) in the YES or NO box. If YES, please provide additional information in the Comment section.

	Questions	Yes	No	Comments
1	Have you ever had a problem with an anaesthetic in the past? Has any member of your family had a problem?	☐	☐	
2	Is there a history of Malignant Hyperthermia? If yes, who has it?	☐	☐	
3	Do you have neck / jaw or back problems?	☐	☐	
4	Do you have dentures / loose teeth or caps?	☐	☐	
5	History of cigarette use? If yes, how many a day? If quit, when?	☐	☐	
6	Alcohol use? If yes, how often?	☐	☐	
7	Have you recently used "street drugs"? If yes, what kind?	☐	☐	
8	Have you ever had a heart attack? If yes, when?	☐	☐	
9	Do you have angina or chest pains? If yes, how often?	☐	☐	
10	Have you ever had heart failure (fluid in lungs)? If yes, when?	☐	☐	
11	Do you have high blood pressure?	☐	☐	
12	Do you have a heart murmur?	☐	☐	
13	Do your ankles swell frequently?	☐	☐	
14	Do you become short of breath with activity or wake up at night with shortness of breath?	☐	☐	
15	Have you ever had a stroke or had "mini stroke attacks"?	☐	☐	
16	Do you have a pacemaker?	☐	☐	
17	Do you bleed or bruise easily?	☐	☐	
18	Have you ever had a clot in your legs or lungs?	☐	☐	
19	Do you take blood thinners? If so, for how long? Date/time of last dose.	☐	☐	

Rev. 09/2017 (v5) Form 900368

OVER ➡

niagarahealth

Extraordinary Caring. Every Person. Every Time.

Anaesthetic Patient Questionnaire

	Questions	Yes	No	Comments
20	Do you have emphysema, asthma or bronchitis?	☐	☐	
21	Do you have sleep apnea? If yes, do you use special equipment when sleeping?	☐	☐	
22	Are you on oxygen at home?	☐	☐	
23	Do you have diabetes (sugar)? If yes, are you on insulin?	☐	☐	
24	Do you have thyroid problems?	☐	☐	
25	Do you have liver disease or a history of jaundice or hepatitis?	☐	☐	
26	Do you have indigestion, heartburn or a hiatus hernia?	☐	☐	
27	Do you have kidney problems?	☐	☐	
28	Do you have bladder problems?	☐	☐	
29	Do you have epileptic seizures or blackouts? If yes, when was your last seizure? (dd/mm/yyyy)	☐	☐	
30	Have you had any steroids (Cortisone or Prednisone) within the last year? If yes, include dd/mm/yyyy.	☐	☐	
31	Do you have any problems that are not mentioned above?	☐	☐	

Home Medications: Please list any medications you are presently taking−prescription and / or over the counter

Name	Dose	Frequency	Name	Dose	Frequency
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

Please list any surgery you have had in the past. Place an asterisk (*) beside surgery in which you experienced complications:

_____

_____

_____

_____

Signature _____ **Date (dd/mm/yyyy)** _____

0R2

Chart Copy Do Not Destroy

Rev. 09/2017 (v5) Form 900368