JOSEPH BRANT MEMORIAL HOSPITAL

1230 NORTHSHORE BLVD., BURLINGTON, ONTARIO L7R 4C4

PRE-ANAESTHETIC QUESTIONNAIRE

60978 04/2003

Please complete this questionnaire in ink as accurately as possible

PATIENT'S NAME	PATIENT'S AGE

PATIENT'S WEIGHT	PATIENT'S HEIGHT

PLEASE ANSWER THESE QUESTIONS ABOUT YOURSELF (OR THE PATIENT, IF A CHILD) WITH A CHECK (✔) UNDER THE APPROPRIATE COLUMN. EVER HAD ...	NO	YES	STILL HAVE
HEART DISEASE/HEART ATTACK			
ANGINA OR CHEST PAIN			
SHORTNESS OF BREATH			
HIGH BLOOD PRESSURE			
CHEST OR LUNG DISEASE			
PERSISTENT COUGH			
BRONCHITIS			
WHEEZING			
ASTHMA			
SPUTUM			
SWELLING OF ANKLES			
ARTHRITIS			
PNEUMONIA			
DIABETES			
THYROID DISEASE			
KIDNEY TROUBLE			
LIVER DISEASE			
ANEMIA			
EPILEPSY			
STROKE			
CANCER			
BLEEDING PROBLEMS			
FAINTING SPELLS			
DRUG REACTIONS			
REACTIONS TO BLOOD TRANSFUSIONS			
NUMBNESS OR WEAK LIMBS			
HIATUS HERNIA			
AIDS / HIV POSITIVE			
OTHER COMMENTS			

INDICATE YOUR ANSWERS TO THE FOLLOWING QUESTIONS RELATING TO YOURSELF (OR THE PATIENT, IF CHILD) WITH A CHECK (✔)

HAVE YOU EVER BEEN TESTED FOR SICKLE CELL OR THALASSEMIA ANEMIA? ☐ NO ☐ YES RESULT _____

ARE CONTACT LENSES WORN? ☐ NO ☐ YES

ARE HEARING AIDS WORN? ☐ NO ☐ YES

DOES PATIENT SMOKE? ☐ NO ☐ YES HOW MANY ___ HOW LONG ___

DOES PATIENT DRINK ALCOHOL? ☐ NO ☐ YES HOW MUCH _____

IS PATIENT PREGNANT? ☐ NO ☐ YES

DOES PATIENT ENGAGE IN PHYSICAL ACTIVITY? ☐ UNLIMITED ☐ LIMITED

INDICATE WITH A CHECK (✔) UNDER THE APPROPRIATE COLUMN AS TO WHETHER YOU (OR THE PATIENT, IF A CHILD) HAVE EVER TAKEN OR ARE TAKING NOW ANY OF THE DRUGS LISTED BELOW.

DRUG	NO	YES	TAKING NOW
CORTISONE OR STEROIDS			
PAIN PILLS			
TRANQUILIZERS / ANTIDEPRESSANTS			
MEDICATION FOR BREATHING			
WATER PILLS			
POTASSIUM			
BLOOD PRESSURE PILLS			
HEART PILLS			
BLOOD THINNERS/ANTICOAGULANTS			
ASPIRIN (WITHIN LAST 4 DAYS) OR ARTHRITIS PILLS			
DIABETIC PILL			
INSULIN			
OTHER			

PLEASE TURN PAGE OVER AND COMPLETE OTHER SIDE.

PRE-ANAESTHETIC QUESTIONNAIRE (CONTINUED)

PLEASE ANSWER THESE QUESTIONS ON BEHALF OF YOURSELF (OR THE PATIENT, IF A CHILD) BY A CHECK (✓) UNDER THE APPROPRIATE COLUMN	NO	YES
ARE DENTURES BEING WORN?		
ARE THERE ANY CHIPPED, BROKEN OR LOOSE TEETH?		
ARE THERE ANY CAPS, CROWNS OR BRIDGEWORK?		

IMPORTANT WARNING RE DENTAL DAMAGE

During the administration of your anaesthetic and during the recovery period immediately following your operation it may be necessary to suction secretions from your mouth and to place breathing tubes and plastic airways in your mouth to assure clear breathing.

All possible precautions and care are taken to avoid damage to your teeth and dental prosthesis. There is always a possibility for your teeth and dental prosthesis to be damaged in the Operating Room or Recovery Room. It is a recognized risk of anaesthetics and recovery. The personnel performing these procedures shall not be held accountable for expenses related to replacement or repair of any dental damage.

Please discuss your concerns, if any, with the anaesthetist prior to your operation.

HAVE YOU (OR PATIENT, IF A CHILD) HAD PREVIOUS OPERATIONS?

☐ NO ☐ YES ▷ PLEASE LIST THEM BELOW:

IF THERE HAVE BEEN PREVIOUS OPERATIONS, WHAT TYPE OF ANAESTHETIC WAS USED? ☐ LOCAL (FREEZING) ☐ GENERAL (ASLEEP)

ANY PROBLEMS?

☐ NO ☐ YES ▷ SPECIFY:

HAVE ANY FAMILY MEMBERS HAD PROBLEMS WITH ANAESTHETICS? eg. MALIGNANT HYPERTHERMIA?

☐ NO ☐ YES ▷ SPECIFY:

PLEASE WRITE NAMES AND DOSAGES OF MEDICATIONS, VITAMINS AND HERBAL REMEDIES BEING TAKEN AS THEY APPEAR ON DRUG BOTTLES.

WHAT ARE YOU (OR PATIENT, IF A CHILD) ALLERGIC TO? ☐ MEDICATION ☐ LATEX ☐ FOOD ☐ ENVIRONMENT

▷ SPECIFY:

I HAVE READ AND UNDERSTAND THE ABOVE ☐ YES ☐ NO

SIGNATURE OF PERSON COMPLETING	DATE OF COMPLETION

IMPORTANT!

PLEASE FOLLOW YOUR PHYSICIAN'S INSTRUCTIONS ABOUT EATING AND DRINKING.
"NOTHING TO EAT OR DRINK" MEANS **NOTHING** - NO FOOD, NO COFFEE, NO WATER, ETC.
FAILURE TO FOLLOW THESE INSTRUCTIONS MAY NECESSITATE POSTPONING OR CANCELLING ANY PROPOSED OPERATION.
THIS IS ESSENTIAL FOR YOUR OWN SAFETY.