ANESTHETIC QUESTIONNAIRE

IMPORTANT
Please fill this questionnaire out before your pre-Operative Visit.
If no Pre-Op Visit required, please bring with you Day of Surgery.

Anesthesia History:	Yes	No	Explain
1. Have you ever had any problems with anesthetic?			
2. Has anyone related to you ever had problems with anesthetic?			
3. Do you or any of your relatives have Malignant Hyperthermia?			
4. Have you ever developed confusion during a hospital admission?			
5. Have you been told you're difficult to intubate?			

Social History:	Yes	No	Explain
6. Do you smoke cigarettes or have you ever smoked?			
How many years did you smoke for?			
If you used to smoke, when did you quit?			
7. Do you smoke marijuana? How often?			
8. Do you drink alcohol or beer? How many drinks per week?			
9. Do you use any recreational drugs?			

Head and Neck:	Yes	No	Explain
10. Do you have dentures, caps, implants or loose teeth?			
11. Do you have any problems opening you mouth fully?			
12. Do you have problems with your neck? (Arthritis, surgery, etc.)			

Cardiovascular System:	Yes	No	Explain
13. Can you walk two blocks or two flights of stairs without stopping?			
14. Do you take any medication to thin you blood (including Baby Aspirin)?			

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Cardiovascular System:	Yes	No	Explain
15. Have you ever had a blood transfusion?			
16. Have you been told to take antibiotics prior to dental work or surgery?			
17. Do you or any of your relatives have sickle cell disease or traits?			
18. Do you have High Blood Pressure?			
19. Have you had a Heart Attack or Angina?			
20. Previous Stents, Cardiac bypass surgery or Ablation?			
21. Do you have Heart Failure or heart rhythm abnormalities?			
22. Do you have a Pacemaker or Implantable Defibrillator (ICD) in place? Date of last pacemaker/ ICD check:_____			
23. Do you have Heart Valve Problems, Valve Replacement or a "Murmur"?			
24. Have you had a Stroke or Mini Stroke (TIA) previously?			
25. Any Peripheral Vascular Disease or Problems with circulation?			
26. Have you had Blood Clots (phlebitis), or Pulmonary Embolism or DVT?			

Respiratory System:	Yes	No	Explain
27. Do you ever have difficulty breathing even when resting or sitting?			
28. Does shortness of breath ever wake you up at night?			
29. Have you ever used puffers or home oxygen for your breathing?			
30. Do you have Asthma, Chronic Bronchitis, and or Emphysema?			
31. Do you ever wheeze or have a chronic cough?			
32. Have you had a recent respiratory infection, cough or common cold?			
33. Do you have sleep apnea or use a CPAP at night?			
34. Have you been told that you snore loudly or stop breathing when you sleep?			

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Other Systems, Have you had or do you have:	Yes	No	Explain
35. Diabetes Type 1 or 2			
36. Thyroid Problems			
37. Hiatus Hernia/ reflux or frequent acid indigestion			
38. Hepatitis, HIV or Tuberculosis			
39. Cirrhosis or Jaundice			
40. Kidney problems or hemo/peritoneal dialysis			
41. Epilepsy or Seizures			
42. Arthritis			
43. Neurological or muscular disease			
44. Glaucoma or Eye Problems			
45. Chronic Pain or Fibromyalgia			
46. Any cortisone injections or prednisone use			
47. Anemia or low blood count			
48. MRSA, VRE or ESBL			
49. Been admitted to hospital for any reason within the last 12 months			
50. Date of last menstrual period? Date: _____			

Please list any other medical problems not mentioned above:

_____

_____

_____

Please List your Previous Surgeries:

Year	Surgery	Year	Surgery

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ANESTHETIC QUESTIONNAIRE

Pre-Surgery Medication Review

Allergies	Reaction
Agents (i.e. drugs or foods)	(i.e. hives, rash, swelling, difficulty breathing)

Community Pharmacy
Name:
Phone #:

Medications Taken by Patient

Shaded Areas Will be Completed with Operative Staff at Pre-Operative appointment

Name of Drug	Dose	Frequency/ Directions	Bring Own Medication	Hold Medication

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ANESTHETIC QUESTIONNAIRE

Non-Prescription Medications Taken by Patient
(Herbal, OTC, Vitamins and Minerals & Recreational)

Shaded Areas Will be Completed with Operative Staff at Pre-Operative appointment

Name of Drug	Dose	Frequency/ Directions	Hold Medication

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ANESTHETIC QUESTIONNAIRE

Nursing Notes

HT: cm	WT: kg	BMI:
BP:	HR:	SpO2:
Incentive Spirometry Given: Yes / No		
Reviewed Pre-Op and Post-Operative Instructions: Yes / No		
Caesarean Section: Pre Pregnancy Weight: kg		
Reviewed by RN Signature:		
Date:		

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