Royal Victoria Regional Health Centre

www.rvh.on.ca

# ANESTHETIC QUESTIONNAIRE

NAME: _____

DOB: _____

HRN: _____

(addressograph)

**IMPORTANT!**
**Fill this out before you see the anesthesiologist.**
It helps the doctor giving your anesthetic (the anesthesiologist) to provide you with safe care.
***Don't forget to bring it with you on the day of your procedure or pre-operative visit.***

| **Anesthesia History:** | **Yes** | **No** | **Explain** |
|---|---|---|---|
| 1. Have you ever had any problems with an anesthetic? | ❑ | ❑ | |
| 2. Has anyone related to you ever had problems with an anesthetic? | ❑ | ❑ | |
| 3. Do you or any of your relatives have Malignant Hyperthermia or Pseudocholinesterase Deficiency? | ❑ | ❑ | |
| 4. Have you ever developed confusion during a hospital admission? | ❑ | ❑ | |

**Social History:** (Smoking, alcohol, and other recreational drugs can affect your anesthetic)

| | | | |
|---|---|---|---|
| 5. Do you smoke cigarettes or have you ever smoked cigarettes? How many years have you or did you smoke for? _____ If you used to smoke, when did you quit? _____ | ❑ | ❑ | |
| 6. Do you smoke or use marijuana? How often? _____ | ❑ | ❑ | |
| 7. Do you drink alcohol or beer? How many drinks per day _____ per week _____ | ❑ | ❑ | |
| 8. Do you use recreational drugs (e.g. cocaine, ecstasy, crystal meth)? | ❑ | ❑ | |

**Head and Neck:**

| | | | |
|---|---|---|---|
| 9. Do you have dentures, caps, bridgework, implants or loose teeth? | ❑ | ❑ | |
| 10. Do you have any problems opening your mouth fully? | ❑ | ❑ | |
| 11. Do you have problems with your neck? (e.g. arthritis, surgery, etc.) | ❑ | ❑ | |

**Cardiovascular System (heart, blood pressure):**

| | | | |
|---|---|---|---|
| 12. Can you walk two blocks or climb two flights of stairs without stopping? | ❑ | ❑ | |
| 13. Do you take medication to thin your blood? | ❑ | ❑ | |
| 14. Have you ever had a blood transfusion? | ❑ | ❑ | |
| 15. Did you have any problems following your transfusion? | ❑ | ❑ | |
| 16. Do you take antibiotics prior to dental work or surgery? | ❑ | ❑ | |
| 17. Do you or any of your relatives have sickle cell disease or trait? | ❑ | ❑ | |

**Have you had or do you have:**

| | | | |
|---|---|---|---|
| 18. High Blood Pressure | ❑ | ❑ | |
| 19. Heart Attack or angina | ❑ | ❑ | |
| 20. Stents or cardiac bypass surgery | ❑ | ❑ | |
| 21. Heart failure or heart rhythm abnormalities | ❑ | ❑ | |
| 22. Do you have a pacemaker or Implantable Defibrillator (ICD)? | ❑ | ❑ | |
| 23. Heart Valve Problems or Valve Replacement or "murmur" | ❑ | ❑ | |
| 24. Stroke or Mini Stroke (TIA) | ❑ | ❑ | |
| 25. Peripheral Vascular Disease/problems with circulation | ❑ | ❑ | |
| 26. Blood Clots (Phlebitis) or pulmonary embolism | ❑ | ❑ | |



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NAME: _____

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| Respiratory System (lungs and breathing) | 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? | ❑ | ❑ | _____ |
| **Have you had or do you have?** | | | |
| 30. Asthma/chronic bronchitis/emphysema/wheezing/chronic cough | ❑ | ❑ | _____ |
| 31. Recent respiratory infection, cough or common cold | ❑ | ❑ | _____ |
| 32. Sleep apnea, severe snoring or breath holding at night | ❑ | ❑ | _____ |
| **Other Systems:** | | | |
| **Have you had or do you have?** | | | |
| 33. Diabetes Type 1 or 2 | ❑ | ❑ | _____ |
| 34. Thyroid Problems | ❑ | ❑ | _____ |
| 35. Hiatus Hernia/reflux or frequent acid indigestion | ❑ | ❑ | _____ |
| 36. Crohn's disease or Ulcerative Colitis | ❑ | ❑ | _____ |
| 37. Rectal bleeding or stomach ulcers | ❑ | ❑ | _____ |
| 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 taken any cortisone-like medication (e.g. Prednisone) in the last year | ❑ | ❑ | _____ |
| 47. Cancer Please specify where: _____ | ❑ | ❑ | _____ |
| 48. Anemia/low blood count | ❑ | ❑ | _____ |
| 49. Is there a chance you may be pregnant? | ❑ | ❑ | _____ |

Please list any other medical problems not mentioned above. _____

_____

Please list previous surgeries and hospital admissions or visits below.

| Year | Surgery or Hospital Admission | Year | Surgery or Hospital Admission |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Do you have any questions about your anesthetic? _____

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# PRE-SURGERY MEDICATION REVIEW

PATIENT NAME: _____

DOB: _____

HRN: _____

(addressograph)

## TO THE PATIENT: Please complete as much of the information below as possible

Community Pharmacy(s): _____ Tel. # _____

_____ Tel. # _____

Height: _____ cm _____ inches Weight: _____ kg _____ lbs

## ALLERGIES

**(eg. hives, rash, swelling, difficulties breathing)**

| Agent (eg. drugs, foods) | Type of reaction? | Age at occurrence |
|---|---|---|
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## INTOLERANCES

**(eg. nausea, upset stomach, dizziness, hallucinations)**

| Agent (eg. drugs, foods) | Comments |
|---|---|
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| | |

Pre-Surgery:
Nurse Employee #: _____ Nurse Signature: _____ Date: _____

Surgery-Preparation:
Nurse Employee #: _____ Nurse Signature: _____ Date: _____

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# PRE-SURGERY MEDICATION REVIEW

PATIENT NAME: _____

DOB: _____

HRN: _____

## MEDICATIONS TAKEN BY PATIENT

*(please fill out as completely as possible - **NOT SHADED AREAS**)*

| Pt. to Bring Own (✓) | Pt. to ask about holding preop (✓) | Name of Drug | Dose | Directions | Date/Time Last Dose Taken |
|---|---|---|---|---|---|
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## NON-PRESCRIPTION MEDICATIONS

**(eg. herbals, OTC, vitamins & minerals, recreational)**

| Pt. to ask about holding preop (✓) | Name of Drug | Dose | Directions | Date/Time Last Dose Taken |
|---|---|---|---|---|
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R.PSMR