Brant Community Healthcare System
The Willett, Paris
The Brantford General

PRE-OP PATIENT ANAESTHESIA QUESTIONNAIRE

List All Allergies (e.g. Drugs, Food, Dyes, Latex) and what the reaction was:

NAME patName
ADDRESS patStreetAddress patAddressLine2
patCityAddress patProvince patPostalCode
PHONE NO. patHomePhone.default
SEX patSex
DATE OF BIRTH patBirthdate.yyyysmmsdd
O.H.C.N. patHN patVersionCode

Height: ...].latest_value Weight: ...t:].latest_value BMI: ...st_value

BP: ...:].latest_value HR ...:].latest_value

Please answer all questions. Please explain "yes" answers below.

	MEDICAL HISTORY	YES	NO		MEDICAL HISTORY	YES	NO
1.	Have you or anyone in your family ever had a bad reaction to an anaesthetic?	☐	☐	18.	Have you ever injured your neck?	☐	☐
2.	Have you ever had a heart attack?	☐	☐	19.	Any liver problems? E.g. hepatitis, jaundice	☐	☐
3.	Have you ever had angina, chest pain or chest tightness?	☐	☐	20.	Do you have a hiatal hernia, heartburn, ulcer or problems with stomach acid?	☐	☐
4.	Do you have a significant heart murmur or palpitations?	☐	☐	21.	Have you had kidney problems?	☐	☐
5.	Do you have a pacemaker, ablation or implanted defibrillator?	☐	☐	22.	Do you consume more than two alcohol drinks per day?	☐	☐
6.	Do you have high blood pressure?	☐	☐	23.	have you taken street drugs?	☐	☐
7.	Can you climb 1 flights of stairs without shortness of breath or chest pain?	☐	☐	24.	Do you have diabetes?	☐	☐
8.	Do you ever wake up having trouble breathing?	☐	☐	25.	Do you have thyroid problems?	☐	☐
9.	Do you have or have you been referred for sleep apnea or used a CPAP machine?	☐	☐	26.	Have you taken steroids (e.g. Prednisone) by mouth or IV in the last 6 months?	☐	☐
10.	Have you had asthma, bronchitis, tuberculosis or prolonged coughing?	☐	☐	27.	Are you being treated for depression or any other mental health problems?	☐	☐
11.	Do you use oxygen at home?	☐	☐	28.	Are there any other unusual problems you have had checked by a physician?	☐	☐
12.	Do you or have you ever smoked? Number of cigarettes per day _____ Number of years _____ If you have, when did you quit? # Years ago _____	☐	☐	29.	Do you or any family member have an abnormal tendency to bleed or any other blood problems? Is there a family history of sickle cell problems?	☐	☐
13.	Have you ever had numbness, tingling or weakness in your arms or legs?	☐	☐	30.	Do you have deep vein thrombosis or leg or lung blood clots?	☐	☐
14.	Have you had a stoke or seizure?	☐	☐	31.	If female, could you possibly be pregnant?	☐	☐
15.	Have you ever had blackouts of fainting spells?	☐	☐	32.	Do you have reason to refuse blood transfusion?	☐	☐
16.	Do you have arthritis that is being treated by a physician?	☐	☐	33.	Have you been in hospital in the past 12 months?	☐	☐
17.	Have you ever had low back problems?	☐	☐	33.	Have you had exposure to or been diagnosed with Methicillin-Resistant Staphylococcus Aureus, Vancomycin Resistant Enterococci, Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome, Hepatitis A, B or C?	☐	☐

"Yes Answers" explanations here:

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MEDICATION HISTORY

Have you ever had chemotherapy? ☐ No ☐ Yes

Have you ever had radiotherapy? ☐ No ☐ Yes

NAME patName
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patCityAddress patProvince patPostalCode
PHONE NO. patHomePhone.default
SEX patSex
DATE OF BIRTH patBirthdate.yyyysmmsdd
O.H.C.N. patHN patVersionCode

Are you taking any medications (prescription and over the counter drugs) ☐ No ☐ Yes
If yes please list all medications and the dose below:

1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.

ANAESTHETIC HISTORY

Have you been put to sleep before? ☐ No ☐ Yes Have you had a spinal/epidural before? ☐ No ☐ Yes

Have you ever been told it was difficult to put a breathing tube in? ☐ No ☐ Yes

Please list all of your operations, anaesthetic type used, the hospital and any ill effects your experienced.

Operation	Anaesthetic Type General/Spinal/Epidural /Local	Which Hospital	Side Effects

Do you have any objections to any of the following student observing you operation?

Medical ☐ No ☐ Yes **Paramedical (Nursing, Physio, OT, etc.)** ☐ No ☐ Yes **High School Co-op** ☐ No ☐ Yes

Health Care Industry Representative (advice and support only) ☐ No ☐ Yes

Do you have any special concerns or questions you wish to discuss with your Anaesthesiologist?
If yes, please describe:

Do you have dentures, or a partial plate? ☐ No ☐ Yes

Do you have any caps on your teeth? ☐ No ☐ Yes

Do you have any loose, chipped or broken teeth? ☐ No ☐ Yes

Do you have any jaw joint (TMJ) problems? ☐ No ☐ Yes

Anaesthesiology Consult Chart for Review ☐ N/A ☐ Yes

Patient Signature Date: currentDate.default