NIAGARA HEALTH SYSTEM
SYSTÈME DE SANTÉ DE NIAGARA
☐SCG ☐WCG ☐GNG ☐OSS

ANESTHETIC PATIENT QUESTIONNAIRE

Patient Name (Last, First)_____

Date of Birth _____
dd/mm/yyyy

Date of Surgery _____
dd/mm/yyyy

Name of Surgeon_____

Name you would like to be called:_____

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

Relationship_____

Allergies:_____

MRSA Exposure: ☐ Yes ☐ No VRE Exposure: ☐ Yes ☐ No

Instructions: Please read all questions carefully 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.			

OVER ➔

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Patient Name (Last, First)_____

Date of Birth _____
dd/mm/yyyy

Date of Surgery _____
dd/mm/yyyy

Name of Surgeon_____

ANESTHETIC 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/yy)			
30. Have you had any steroids (Cortisone or Prednisone) within the last year? If yes, include dd/mm/yy.			
31. Do you have any problems that are not mentioned above?			

Please list any medications: (If further space is needed please attach a list)

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 * beside surgery in which you experienced complications. _____

_____

_____

_____

Date: _____
dd/mm/yy

Signature: _____

DISPONIBLE EN FRANCAIS

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