Pre-Anesthetic Questionnaire

Patient Name: _____

Address: _____ City_____ PC_____

Home Phone: _____ Mobile: _____

Preferred method of contact by phone: ☐ Cell Phone Number ☐ Home Phone

Birth Date: _____ Gender: ☐ Male ☐ Female

Family Physician: _____

Care Card # _____ **Allergies: _____**

Procedure(s) to be performed:

_____

It is important that we are aware of your general health and medical background. In some instances this can critically affect the safety of some procedures. This information will be kept confidential. Please assist our anesthesiologist by completing the following information:

Do these apply to you?

CARDIOVASCULAR	**Yes**	**No**
• Chest pain or angina	☐	☐
• History of Heart Attack	☐	☐
• History of a Stroke	☐	☐
• Heart Murmur	☐	☐
• High Blood Pressure	☐	☐
• Irregular Pulse/Palpitations	☐	☐
• Do you take blood thinners?	☐	☐
• Do you take antibiotics before Dental work?	☐	☐
RESPIRATORY		
• Asthma/Bronchitis	☐	☐
• Emphysema	☐	☐
• Are you short of breath easily	☐	☐
• Productive Cough	☐	☐
• Do you smoke?	☐	☐
• Have you quit smoking? If YES please specify when _____	☐	☐
RENAL		
• Kidney problems/failure	☐	☐
• Difficulty urinating	☐	☐
GASTROINTESTINAL		
• Heartburn/Hiatus Hernia	☐	☐
• Stomach Ulcers	☐	☐
• History of Hepatitis	☐	☐
OTHER		
• Diabetes	☐	☐
• Thyroid Problems	☐	☐
• Anemia	☐	☐
• Bleeding Disorders	☐	☐
• Leg blood clots	☐	☐
• Rheumatoid Arthritis	☐	☐
• Ankylosing Spondylitis	☐	☐
• Dry Eyes	☐	☐
• Glaucoma	☐	☐

OTHER Conditions	**Yes**	**No**
• Blackouts/Seizures	☐	☐
• Faint easily	☐	☐
• HIV/ AIDS Infection	☐	☐
• Tumours/Malignancy	☐	☐
• Possibility of Pregnancy	☐	☐
• Contact Lenses	☐	☐
• Dentures/Bridgework	☐	☐

- Do you drink more than one alcoholic drink each day? ☐ yes ☐ no
- Have you ever injected street drugs? ☐ yes ☐ no

Please list **all** medications that you take:

_____

_____

- Do you have allergies to medications, latex or tape? ☐ yes ☐ no

  Please describe further if yes:

  _____
- Have you or your family members had severe problems with anesthesia? ☐ yes ☐ no

  If yes, please describe:

  _____
- Do you have any other Medical Problems that we should be aware of? ☐ yes ☐ no

  _____
- Height: _____ft/inches Weight: _____lbs

If you answered yes to any of the above questions, please give details here:

_____

Please list all your previous surgeries (including cosmetic):

_____

Patient Signature: _____ Date: _____