



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?  | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 2. Has anyone related to you ever had problems with an anesthetic?                                 | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3. Do you or any of your relatives have Malignant Hyperthermia or Pseudocholinesterase Deficiency? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 4. Have you ever developed confusion during a hospital admission?                                  | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

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

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

### Head and Neck:

- |  |                          |                          |       |
|--|--------------------------|--------------------------|-------|
| 9. Do you have dentures, caps, bridgework, implants or loose teeth?      | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 10. Do you have any problems opening your mouth fully?                   | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 11. Do you have problems with your neck? (e.g. arthritis, surgery, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

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

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

### Have you had or do you have:

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





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HRN: \_\_\_\_\_

### Respiratory System (lungs and breathing)

- 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?

Yes No

- 
- 
- 

Explain

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### 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

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### 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?

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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? \_\_\_\_\_

