RVH
Royal Victoria
Regional Health Centre

www.rvh.on.ca

ANESTHETIC QUESTIONNAIRE

NAME: _____

DOB: _____

HRN: _____

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 this completed form 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. Have you ever been told that it was difficult inserting a breathing tube for you?	☐	☐	_____
3. Do you or any of your relatives have Malignant Hyperthermia or Pseudocholinesterase Deficiency, or problems with an anesthetic?	☐	☐	_____
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?	☐	☐	_____
Number of cigarettes a day:_____ Number of years you smoked?			_____
If you used to smoke, when did you quit? _____			
6. Do you smoke or use marijuana?	☐	☐	_____
How often? _____ How much? _____			
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)?	☐	☐	_____
Type:_____ Amount: _____ How often: _____			

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?	☐	☐	_____
If yes, **when** and **where** was your last blood transfusion?			_____
15. Did you have any problems following your transfusion?	☐	☐	_____
16. Do you take antibiotics prior to dental work or surgery?	☐	☐	_____

Have you had or do you have:

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

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Respiratory System (lungs and breathing)	Yes	No	Explain
28. Do you ever have difficulty breathing even when resting or sitting?	☐	☐	_____
29. Does shortness of breath ever wake you up at night?	☐	☐	_____
30. Have you ever used puffers or home oxygen for your breathing?	☐	☐	_____

Have you had or do you have?

31. Asthma/chronic bronchitis/emphysema/wheezing/chronic cough	☐	☐	_____
32. Recent respiratory infection, cough or common cold	☐	☐	_____
33. Sleep apnea, severe snoring or breath holding at night	☐	☐	_____
34. Do you use a CPAP machine?	☐	☐	_____

Other Systems:
Have you had or do you have?

35. Diabetes Type 1 or 2 (Insulin / Medication / Diet controlled?)	☐	☐	_____
36. Thyroid Problems	☐	☐	_____
37. Hiatus Hernia/reflux or frequent acid indigestion	☐	☐	_____
38. Crohn's disease or Ulcerative Colitis	☐	☐	_____
39. Rectal bleeding or stomach ulcers	☐	☐	_____
40. Hepatitis, HIV or Tuberculosis	☐	☐	_____
41. Cirrhosis or jaundice	☐	☐	_____
42. Kidney problems or hemo/peritoneal dialysis	☐	☐	_____
43. Epilepsy or Seizures	☐	☐	_____
44. Rheumatoid Arthritis/ Osteoarthritis	☐	☐	_____
45. Neurological or muscular disease	☐	☐	_____
46. Glaucoma or Eye Problems	☐	☐	_____
47. Chronic pain or fibromyalgia	☐	☐	_____
48. Any cortisone injections or taken any cortisone-like medication (e.g. Prednisone) in the last year	☐	☐	_____
49. Cancer Please specify where: _____	☐	☐	_____
50. Anemia/low blood count	☐	☐	_____
51. Do you or any of your relatives have thalassemia, sickle cell disease or trait?	☐	☐	_____
52. 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? _____