Markham Stouffville Hospital
Oak Valley Health

Pre-Anaesthetic Patient Questionnaire

Date Completed: _____

Surgical History

List of all previous surgical procedures: ☐ No previous surgical procedures

Procedure	Hospital	Year

General History	Yes	No	Unknown
Have you had any type of anaesthesia in the past? ☐ Spinal/Epidural ☐ General ☐ Regional	☐	☐	☐
Have you or a relative (including aunts/uncles, cousins) had any problems with anaesthesia? e.g. malignant hyperthermia, pseudocholinesterase deficiency, breathing problems, or difficulty with insertion of the anaesthesia breathing tube?	☐	☐	☐
Do you smoke? Number of cigarettes a day: _____ Number of years smoking: _____	☐	☐	☐
If you smoked previously, when did you stop smoking?	☐	☐	☐
How many alcoholic drinks do you have per week?	☐	☐	☐
Do you use recreational drugs? Type: _____ Amount: _____ How often: _____	☐	☐	☐
Have you taken cortisone, prednisone or other steroids in the last 6 months? (not including Cortisone Injections)	☐	☐	☐
Do you have cancer, or have had it in the past? Type: _____ Year: _____	☐	☐	☐
Do you have a history of HIV?	☐	☐	☐
Could you be pregnant?	☐	☐	☐
Do you have a history of complications during pregnancy? e.g. toxemia	☐	☐	☐
Do you have capped or loose teeth, partial or full dentures or veneers?	☐	☐	☐
Do you use glasses, contact lenses or hearing aids? Type: _____	☐	☐	☐

Respiratory	Yes	No	Unknown
Have you had a cold, flu, or chest infection in the 6 weeks?	☐	☐	☐
Have you ever had Bronchitis or Pneumonia?	☐	☐	☐
Do you have a cough with sputum?	☐	☐	☐
Do you have trouble with your breathing? Have you ever been diagnosed with: ☐ Asthma ☐ Tuberculosis ☐ Emphysema ☐ COPD	☐	☐	☐
Do you snore excessively or have Sleep Apnea? If you have Sleep Apnea, is it treated with: ☐ C-PAP	☐	☐	☐

Cardiovascular	Yes	No	Unknown
Can you walk two blocks or climb two flights of stairs without stopping?	☐	☐	☐
Do you have high blood pressure?	☐	☐	☐
Have you ever had ☐ Angina ☐ Heart Attack	☐	☐	☐
Do you have an irregular heartbeat or Rhythm problems?	☐	☐	☐
Do you have a heart murmur?	☐	☐	☐
Do you have a history of Congestive Heart Failure?	☐	☐	☐
Do you have an implantable cardiac device? ☐ Pacemaker ☐ Defibrilator ☐ Other: _____	☐	☐	☐
Do you have problems with circulation (Peripheral Vascular Disease)	☐	☐	☐

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Gastrointestinal/Renal	Yes	No	Unknown
Have you ever had Hepatitis? ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C	☐	☐	☐
How often do you have heartburn _____ days/week	☐	☐	☐
Do you have gastric ulcers?	☐	☐	☐
Have you ever had kidney disease?	☐	☐	☐

Endocrine	Yes	No	Unknown
Do you have Diabetes? ☐ Type 1 ☐ Type 2 How is it managed? ☐ Diet controlled ☐ Oral Medication ☐ Insulin	☐	☐	☐
Do you have thyroid problems?	☐	☐	☐

Neurological/Musculoskeletal	Yes	No	Unknown
Have you ever had a stroke or Transient Ischemic Attack? When? _____	☐	☐	☐
Have you ever had a seizure(s)?	☐	☐	☐
Do you have any neurological or muscular disease? Type: _____	☐	☐	☐
Do you have Arthritis? ☐ Osteoarthritis ☐ Rheumatoid arthritis ☐ Other Arthritis	☐	☐	☐
Do you have a condition/previous injury affecting your neck or jaw?	☐	☐	☐

Hematological	Yes	No	Unknown
Do you have bleeding problems, or have been diagnosed with a bleeding disorder?	☐	☐	☐
Are you on any blood thinners?	☐	☐	☐
Do you have: ☐ Thalassemia ☐ Sickle Cell Disease	☐	☐	☐
Have you had a blood transfusion in the last 3 months?	☐	☐	☐

Other

Is there anything else that you would like us to know about your medical history?

Allergies

Allergy/Adverse Reaction	Type of Reaction	Allergy/Adverse Reaction	Type of Reaction
1		6	
2		7	
3		8	
4		9	
5		10	

Medications

Medication Name	Dose	Medication Name	Dose
1		6	
2		7	
3		8	
4		9	
5		10	