NAME ON HEALTHCARD_____

DATE OF BIRTH_____

William Osler Health System

Pre-Anesthetic Questionnaire

		Yes	No	I don't know
1.	Have you been in or to the hospital in the last 90 days, if yes why? _____			
2.	Do you have any history of heart attack, or irregular heart beat?			
3.	Do you get chest pain or chest pressure/tightness?			
4.	Do you have a pacemaker or ICD (implantable cardiac defibrillator)?			
5.	Have you had coronary bypass or a coronary angioplasty with stents?			
6.	Do you have a history of high blood pressure? If yes, what is your blood pressure reading normally?			
7.	Have you had an electrocardiogram (ECG) in the last year?			
8.	Have you had congestive heart failure? (fluid in lungs) If yes, when? _____			
9.	Do you sleep sitting up?			
10.	Do you ever wake up at night because you can't catch your breath?			
11.	Do you use puffers or inhalers on a regular basis?			
12.	Have you had frequent hospital admissions for respiratory issues like asthma/emphysema/COPD exacerbation?			
13.	Have you had pneumonia in the last 4 months?			
14.	Do you have shortness of breath on exercise or exertion?			
15.	Have you ever been diagnosed with sleep apnea?			
16.	Are you on prescribed Continuous Positive Airway Pressure (CPAP) for sleep apnea? If yes, do you use your machine_____?			
17.	Are you on oxygen at home?			
18.	Do you smoke? If yes, how many cigarettes per day do you smoke? _____			
19.	Do you have a history of smoking more than 1 pack of cigarettes per day for 20 years?			
20.	Are you diabetic?			
21.	Do you have a history of stroke with any lasting physical losses?			
22.	Are you currently on an anticoagulant/blood thinning therapy other than aspirin (e.g., Warfarin or Coumadin, Plavix, Brilinta, Effient) ? If yes, why _____?			
23.	Do you have a bleeding disorder?			
24.	Have you had a seizure in the last year?			
25.	Are you on dialysis for renal failure?			
26.	Do you have current known liver disease? (cirrhosis, hepatitis, bleeding varices)			
27.	Do you have any history of thyroid problems?			
28.	Are you taking medications for chronic pain?			
29.	Have you had cortisone, prednisone, or steroids in the last six months?			
30.	Have you or anyone in your family had severe problems with anesthetics in the past like difficult airway, prolonged muscle weakness or malignant hyperthermia?			

		Yes	No	I don't know
31.	Do you suffer from heart burn or acid reflux?			
32.	Do you have any capped, loose, or false teeth?			
33.	Is there a possibility that you are pregnant?			
34.	Have you ever been tested for any of the following: MRSA, MRO, VRE? If yes, write date and what you were tested for _____			
35.	Do you use recreational drugs (e.g., marijuana, cocaine, ecstasy, crystal meth)? If yes, write the drug or medication _____			
36.	Do you drink alcohol? If yes, write daily/weekly amount _____			
37.	Do you have any food or drug allergies? If yes, write allergies. _____ _____			
38.	Do you have a LATEX allergy?			
39.	Do you have any known communicable diseases?			

List any major illnesses and operations you have had:

☐ **I do not have any major illnesses or past operations to report**

Date	Major Illnesses	Operations	Date

List your current medications (include "over the counter" and herbal medications):

☐ **I am not currently taking any medications**

Current Medications	Dosage	How many times per day

Completed by: _____ **If not patient, state relationship:** _____

Name: _____ **Date:** _____