Preoperative Anaesthetic Questionnaire

Patient Identification

The following questions relate to your anaesthetic

	Yes	No	Do Not Know
1. Do you have any heart trouble?.....	☐	☐	☐
2. Have you ever had a heart attack?.....	☐	☐	☐
3. Do you ever have chest pain or angina?.....	☐	☐	☐
4. Do you have a pacemaker or ICD (implantable cardiac defibrillator)	☐	☐	☐
5. Do you have high blood pressure?.....	☐	☐	☐
6. Do you ever have difficulty with your breathing?.....	☐	☐	☐
7. Do you have Sleep Apnea?.....	☐	☐	☐
8. Do you use a CPAP machine to help you breath.....	☐	☐	☐
9. Do you get short of breath climbing one flight of stairs?.....	☐	☐	☐
10. Do you have a cough.....	☐	☐	☐
11. Do you have asthma, bronchitis, or emphysema?.....	☐	☐	☐
12. Do you smoke?.....	☐	☐	☐

If YES: Cigarettes per day?_____Number of years smoking?_____

If NO: Are you a lifetime non-smoker? _____

If you stopped smoking: When?_____Cigarettes per day?_____# Years smoking?_____

13. Any history of jaundice or hepatitis or liver disease?.....	☐	☐	☐
14. Do you have a bleeding disorder?.....	☐	☐	☐
15. Do you have diabetes, heart disease etc.....	☐	☐	☐
16. Any history of thyroid problems?.....	☐	☐	☐
17. Do you have any kidney problems?.....	☐	☐	☐
18. Do you have Epilepsy or have you ever had a seizure or convulsion?	☐	☐	☐
19. Have you had a stroke?.....	☐	☐	☐
20. Have you ever had a blood transfusion?.....	☐	☐	☐
21. Have you had cortisone, prednisone, or steroids in the last 6 months?	☐	☐	☐
22. Have you or members of your family had problems with anaesthetics?	☐	☐	☐

If YES ⟶ please explain _____

23. Do you have a history of difficult airway or difficult intubations?	☐	☐	☐
24. Do you suffer from heart burn or acid reflux?.....	☐	☐	☐
25. Do you have any capped, loose, or false teeth?.....	☐	☐	☐
26. Do you have a family history of Malignant Hyperthermia?...	☐	☐	☐
27. Do you have muscle weakness or problems with your joints?	☐	☐	☐
28. If Female, and of childbearing age, is there a possibility that you are pregnant?	☐	☐	☐

Patient Identification

The following questions relate to your anaesthetic

	Yes	No	Do Not Know
29. Do you have HIV?.....	☐	☐	☐
30. Do you have a drug addiction or use any recreational medications?	☐	☐	☐
31. Have you been in hospital over night in last the 6 months?.....	☐	☐	☐
32. Have you ever been tested for any of the following: MRSA, MRO, VRE	☐	☐	☐

Other _____ If YES → when (give date)_____

33. How much alcohol do you drink?_____

34. Consent signed and witnessed?.....	☐	☐	☐
35. Last eaten or drank?_____			
36. Is someone available to drive you home and stay with you?...	☐	☐	
37. Checked lab results?.....	☐	☐	

38. List your Allergies(Bracelet)_____

39. Weight_____ Height_____

40. List any operations and/or major illnesses you have had:

Date	Major Illnesses	Date	Operations

41. List your medications (include over the counter and herbal medications):

Current Medications	Dosage	How many times per day

Completed by: Patient □ Other □ If other, state relationship:_____

Patient Name:_____ Date Completed:_____