NORTH YORK GENERAL

PATIENT QUESTIONNAIRE

DEPARTMENT OF ANAESTHESIA

Failure to fill out this form completely may delay your surgery.

FORM 1677 REV. 9/08

HAVE YOU EVER HAD:	YES	NO	DON'T KNOW	WHEN
Heart Disease/Heart Attack/Chest Pain				
High Blood Pressure				
Shortness of Breath				
Recent Cough/Cold				
Asthma/Wheezing				
Glaucoma				
Epilepsy				
Hepatitis/Jaundice/HIV				
Bleeding Problems/Clotting Problems				
Kidney Problems				
Diabetes				
Blood Transfusion				
Reaction to Local/General Anaesthetic				
Do you wear Contact Lenses? Do you have Caps, Bridges, Crowns, Dentures, Loose Teeth?				
Is there a Family History of Problems with Anaesthetic?				

HAVE YOU EVER HAD:	YES	NO	DON'T KNOW	WHEN
Severe Snoring/Sleep Apnea				
Stroke /"ministroke"/TIA				
Chronic Pain				
Acid Reflux/Ulcer				
Back Problems				
Thyroid Problems				
Blood Thinners/Aspirin				
Joint Replacement				
Artificial Body Parts				
Difficulty Opening Mouth				
Difficulty Moving Neck				
Rheumatoid Arthritis				
Cortisone/Prednisone				

Medications you take including Vitamins/Herbals:

	Dose	Frequency

List previous operations or admissions to a hospital. When?

Do You have any Allergies to any Food Medicine or Latex?:
No ❑ Yes ❑ If Yes - What?

Have you seen a Specialist in the last 5 years? Name and phone #:

❑ Heart Doctor (Cardiologist):

❑ Lung Doctor (Respirologist):

❑ Nerve Doctor (Neurologist):

Possibility of pregnancy: No ❑ Yes ❑

To be completed by nurse on day of surgery:

Cigarettes per Day: Ounces Alcohol per Week:

Time of Last Fluids: Time of Last Food:

Recreational/Street Drugs:

Did You have or ever had any of the following Tests: When?

❑ Exercise Stress Test (Treadmill):

❑ Nuclear Medicine Stress Test (Mibi):

❑ Angiogram/Angioplasty:

❑ Ultrasound of Heart (Echo):

❑ Holter Monitor:

❑ Lung Function:

Pre-Admit Nurse: Date:

Day of Surgery Nurse: Date:

Comments: