U SURGICAL CENTRE

PATIENT QUESTIONNAIRE

DEPARTMENT OF ANAESTHESIA

	Yes	No	Do not Know
1. Do you have an 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 get short of breath climbing one flight of stairs?...	☐	☐	☐
8. Do you have a cough?..	☐	☐	☐
9. Do you have asthma, bronchitis, or emphysema?..	☐	☐	☐
10. Do you have sleep apnea?...	☐	☐	☐
11. Do you smoke?..	☐	☐	☐

If yes: Cigarettes per day?..............# Years of smoking?...............................

If no: Are you a lifetime non-smoker?...

If you stopped smoking: When?........Cigarettes per day?.........# Years smoking?...........

	Yes	No	Do not Know
12. Any history of jaundice or hepatitis or liver disease?..	☐	☐	☐
13. Do you have a bleeding disorder?...	☐	☐	☐
14. Do you have diabetes?...	☐	☐	☐
15. Any history of thyroid problems?...	☐	☐	☐
16. Do you have any kidney problems?..	☐	☐	☐
17. Do you have Epilepsy or have you ever had a seizure?....................	☐	☐	☐
18. Have you ever had a stroke?...	☐	☐	☐
19. Have you ever had a blood transfusion?..	☐	☐	☐
20. Have you had cortisone, prednisone or steroids in the last 6 months?.....................	☐	☐	☐
21. Have you or members of your family had problems with anaesthetics?..................	☐	☐	☐
22. Do you have a history of difficult airway or difficult intubation?...............................	☐	☐	☐
23. Do you suffer from heart burn or acid reflux?..	☐	☐	☐
24. Do you have any capped, loose or false teeth?...	☐	☐	☐

SURGICAL CENTRE

PATIENT QUESTIONNAIRE
DEPARTMENT OF ANAESTHESIA

	Yes	No	Do not Know
25. Do you have a family history of Malignant Hyperthermia?...	☐	☐	☐
26. Do you have muscle weakness or problems with your joints?......................................	☐	☐	☐
27. If female, and of childbearing age, is there a possibility that you are pregnant?..........	☐	☐	☐
28. Do you have HIV?..	☐	☐	☐
29. Do you have a drug addiction or use any recreational medications?............................	☐	☐	☐

30. List how much alcohol do you drink:

....

31. List your allergies:

....
....

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

....
....
....

33. List your medications (including over the counter and herbal medications):

Current Medications	Dosage	How many times per day