



**Preoperative Anaesthetic Questionnaire**

Patient Identification

The following questions relate to your anaesthetic

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

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?.....           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you have a bleeding disorder?.....                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you have diabetes, heart disease etc.....                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Any history of thyroid problems?.....                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Do you have any kidney problems?.....                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Do you have Epilepsy or have you ever had a seizure or convulsion?    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you had a stroke?.....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you ever had a blood transfusion?.....                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you had cortisone, prednisone, or steroids in the last 6 months? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have you or members of your family had problems with anaesthetics?    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If YES → please explain \_\_\_\_\_

- |   |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|
| 23. Do you have a history of difficult airway or difficult intubations? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Do you suffer from heart burn or acid reflux?.....                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Do you have any capped, loose, or false teeth?.....                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Do you have a family history of Malignant Hyperthermia?...          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Do you have muscle weakness or problems with your joints?           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. If Female, and of childbearing age, is there a possibility that you | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

are pregnant?



Patient Identification

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- |  | Yes                      | No                       | Do Not Know              |
|--|--------------------------|--------------------------|--------------------------|
| 29. Do you have HIV?.....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Do you have a drug addiction or use any recreational medications?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Have you been in hospital over night in last the 6 months?.....    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Have you ever been tested for any of the following: MRSA, MRO, VRE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other _____ If YES → when (give date) _____                            |                          |                          |                          |
| 33. How much alcohol do you drink? _____                               |                          |                          |                          |
| 34. Consent signed and witnessed?.....                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Last eaten or drank? _____   |                          |                          |                          |
| 36. Is someone available to drive you home and stay with you?...       | <input type="checkbox"/> | <input type="checkbox"/> |                          |
| 37. Checked lab results?.....  | <input type="checkbox"/> | <input type="checkbox"/> |                          |
| 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: \_\_\_\_\_