

**PRE-ANAESTHETIC QUESTIONNAIRE**

Please Print Name: \_\_\_\_\_

Pre-op Visit  Phone Pre-op

Complete and explain if necessary	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>
1. Are you allergic to anything? If yes, list and reaction: _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you had a recent illness: _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you had a sore throat, a cold or the flu? _____	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you had a general anaesthetic before? _____	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you had problems with an anaesthetic in the past? _____	<input type="checkbox"/>	<input type="checkbox"/>
6. Has anyone related to you ever had an anaesthetic with a Serious complication? E.g. Malignant Hyperthermia _____	<input type="checkbox"/>	<input type="checkbox"/>
7. Is there a history of patient or family allergy to latex? _____	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you taken Aspirin in the last week? _____	<input type="checkbox"/>	<input type="checkbox"/>
9. Could you be pregnant? _____	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you smoke or vape? How often or many per day? _____	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you use recreational drugs? What? How Much? _____	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you use medical marijuana or its' derivatives (CBD oil) <b>Do not use any medical/recreational drugs 48h prior to surgery</b>	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you use alcohol? How much? _____	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you have a history of MRSA or CPE? _____	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you received any blood or blood products recently? If yes, date of transfusion: _____	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you had, or do you have? ( <input checked="" type="checkbox"/> if yes)		
<input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Blood clots (phlebitis)	<input type="checkbox"/> Asthma
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Stroke	<input type="checkbox"/> Shortness of breath/COPD
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Fainting	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Heart attack	<input type="checkbox"/> Anemia (low blood)	<input type="checkbox"/> Hiatus hernia/reflux
<input type="checkbox"/> Angina	<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Kidney problems
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy or seizures
<input type="checkbox"/> Mitral valve prolapse	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Sleep Apnea/CPAP	<input type="checkbox"/> Emphysema /bronchitis	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Bleeding problems	<input type="checkbox"/> Tuberculosis (T.B.)	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> HIV/Hepatitis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Other _____

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**Please turn over and complete page 2**

