SHN
SCARBOROUGH HEALTH NETWORK

Patient Questionnaire
Department of Anesthesia

Failure to fill out this form completely may delay your surgery

300144

HAVE YOU EVER HAD:	YES	NO	DON'T KNOW	WHEN
Reaction to local/general anesthetic	☐	☐	☐	
Family history of problems with anesthetic (e.g. malignant hyperthermia, allergic reaction)	☐	☐	☐	
Difficulty Opening Mouth	☐	☐	☐	
Difficulty Moving Neck	☐	☐	☐	
Caps, bridges, crowns, dentures, loose teeth	☐	☐	☐	
Heart Disease/Chest Pain/Heart Attack/angiogram/cardiac stents	☐	☐	☐	
Heart valve disease/heart murmur	☐	☐	☐	
Pacemaker/ICD	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
Shortness of Breath	☐	☐	☐	
Heavy snoring or sleep apnea	☐	☐	☐	
IF Yes –do you have CPAP?	☐	☐	☐	
Recent Cough/Cold	☐	☐	☐	
Asthma/Wheezing/ COPD	☐	☐	☐	
Diabetes	☐	☐	☐	
IF YES –on insulin?	☐	☐	☐	
Epilepsy/seizures	☐	☐	☐	
Stroke/ "ministroke"/TIA	☐	☐	☐	
Other Neurological disease (Cerebral aneurysm, neuromuscular disease)	☐	☐	☐	

HAVE YOU EVER HAD:	YES	NO	DON'T KNOW	WHEN
Thyroid Problems	☐	☐	☐	
Kidney Problems	☐	☐	☐	
Hepatitis/Jaundice/ liver disease	☐	☐	☐	
Acid Reflux/Ulcer	☐	☐	☐	
Cancer/Chemo/ Radiation	☐	☐	☐	
Back Problems	☐	☐	☐	
Chronic Pain	☐	☐	☐	
Autoimmune Disease (Rheumatoid arthritis, SLE)	☐	☐	☐	
Artificial Body Parts (e.g. joint replacement)	☐	☐	☐	
Contact lenses	☐	☐	☐	
Bleeding/clotting problems	☐	☐	☐	
Blood Thinners / Aspirin	☐	☐	☐	
Cortisone/Prednisone	☐	☐	☐	
History of MRSA, VRE, Covid 19,	☐	☐	☐	

Other disease not mentioned:

Medications you take including Vitamins/Herbals:
(please include a list of meds from Pharmacist)

Medication	Dose	Frequency
Medication #1	mg	Daily
Medication #2	mg	Daily
Medication #3	mg	Daily
Medication #4	mg	Daily
Medication #5	mg	Daily
Medication #6	mg	Daily
Medication #7	mg	Daily
Medication #8	mg	Daily
Medication #9	mg	Daily
Medication #10	mg	Daily
Medication #11	mg	Daily

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Possibility of Pregnancy: No ☐ Yes ☐

Recreational Street drugs:

Marijuana use: No ☐ Yes ☐ How much? Frequency

Tobacco use: No ☐ Yes ☐ How much? Frequency

Alcohol use: No ☐ Yes ☐ How much? Frequency

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

☐ Heart Doctor (Cardiologist)
Doctor's Name | Doctor's Phone #

☐ Lung Doctor (Respirologist)
Doctor's Name | Doctor's Phone #

☐ Nerve Doctor (Neurologist)
Doctor's Name | Doctor's Phone #

☐ Other
Doctor's Name | Doctor's Phone #

Did you have or ever had any of the following Tests. When?

	Date
☐ Exercise stress test (Treadmill)	
☐ Nuclear Medicine Stress Test	
☐ Ultrasound of Heart (Echo)	
☐ Holter Monitor	
☐ Lung Function	

List previous operations or admissions to a hospital. When?

Operation or Admission	
Operation or Admission	
Operation or Admission	
Operation or Admission	
Operation or Admission	
Operation or Admission	
Operation or Admission	
Operation or Admission	

Do you have allergies to medication, food, or latex? No ☐ Yes ☐

ALLERGY	REACTION
Allergy	Reaction
Allergy	Reaction
Allergy	Reaction
Allergy	Reaction

To Be completed by Nurse on day of Surgery :

Time of last fluid: **Time of Last Food:**

Age:_____ WT:_____ HT:_____ BP:_____

P:_____ SaO2:_____ Temp:_____

Pre-admit nurse:

_____ Date:_____

Day Of Surgery Nurse:

_____ Date:_____

Comments:_____

SUBMIT FORM