North Bay Regional Health Centre

Clinical Services
Pre-Anaesthetic Questionnaire

Contact information: Daytime phone: _____Home phone: _____ Cell phone: _____
Who completed this form? ☐ Patient ☐ Other Name/Relationship: _____ Date:_____
Religion: _____ Family Doctor: _____ Surgeon Name: _____
Name of the legal next of kin: _____ Preferred language: _____
Do you have a power of attorney for health care/advance directive/living will? ☐ Yes ☐ No
If you are staying overnight, what type of room do you wish? ☐ Private room ☐ Semi private (fee applies if no insurance)
Name of insurance company: _____ Insurance policy number: _____
Whose name is the insurance in: _____ Relationship: _____ Date of birth: _____
Is this surgery due to a work related injury? ☐ Yes ☐No Name of Employer: _____
WSIB/WCB Claim #_____

	Yes	No	
1.	☐	☐	Have you been hospitalized in the past year? Where? Why?
2.	☐	☐	Is it possible that you are pregnant?
3.	☐	☐	Do you drink more than 2 – 3 alcoholic beverages (includes beer, wine, spirits) per day?
4.	☐	☐	Do you have someone to drive you home after your surgery? Who?
5.	☐	☐	Are you allergic to latex?

Please list all allergies below and your reaction:

Allergic to:	**Reaction:**	**Allergic to:**	**Reaction:**

Medication information

6.	☐	☐	Do you take any blood thinners (anticoagulants)?

Please list all medications you take **OR** ☐ I **do not** take any medications
(include pills, patches, creams, puffers, eye drops, vitamins, herbals, and recreational drugs) or attach your MedsCheck Review list.
Name of the pharmacy you use: _____ Telephone number:_____

Drug	**Dose (mg)**	**How often**	**Reason**

Anesthetic information **Patient Name/J Number:**_____

	Yes	No	If yes provide brief details
7.	☐	☐	Have you ever had an anesthetic before?
8.	☐	☐	Have you ever had any problems with an anesthetic?
9.	☐	☐	Do you or any of your family members have malignant hyperthermia?
10.	☐	☐	Do you have difficulty moving your neck or opening your mouth?
11.	☐	☐	Do you have dentures, caps, or crowns?
12.	☐	☐	Do you have severe or uncontrolled heartburn or acid reflux?
13.	☐	☐	Have you ever smoked? If **yes**, do you still smoke? How much? If **no**, when did you quit?
14.	☐	☐	Do you have asthma, bronchitis, emphysema or COPD? If **yes**, does your breathing problem make daily activities more difficult?
15.	☐	☐	Do you use home oxygen?
16.	☐	☐	Do you have sleep apnea? If **yes**, do you use a CPAP machine? Setting:

Cardiovascular

17.	☐	☐	Have you ever had a heart attack? If **yes**, when?
18.	☐	☐	Have you ever had a bypass? If **yes**, when?
19.	☐	☐	Have you ever had cardiac stents? If **yes**, when?
20.	☐	☐	Do you take pills for high blood pressure?
21.	☐	☐	Do you have a pacemaker?
22.	☐	☐	Do you have an implanted cardiac device (including an implanted cardiac defibrillator)?
23.	☐	☐	Do you get chest pain and/or shortness of breath when you do **one or more** of the following activities? - climb a flight of stairs - walk up a hill - run a short distance - cycle a bike
24.	☐	☐	Do you have a heart murmur or heart valve for which you see a specialist? If **yes,** when was your last echocardiogram? _____ and where was it done? _____
25.	☐	☐	Have you ever had a stroke or mini stroke? If **yes**, when? _____
26.	☐	☐	Have you ever had a blood clot in your leg or lung?
27.	☐	☐	Do you have an abnormal bruising or bleeding disorder?

Other information

28.	☐	☐	Do you have fainting spells or frequent blackouts?
29.	☐	☐	Do you have epilepsy or seizure disorder?
30.	☐	☐	Do you have rheumatoid arthritis?
31.	☐	☐	Do you have diabetes? If **yes**, do you take insulin? _____
32.	☐	☐	Do you have kidney disease?
33.	☐	☐	Have you had any major illnesses?

If yes, list all other health conditions (including mental health issues) and any major operations that have not been mentioned above on the lines below:

Nurses Notes

Department	Signature	Print Name	Date
PAC nurse			
Unit nurse			