MARKHAM STOUFFVILLE HOSPITAL

☐ Markham Site ☐ Uxbridge Site

ANAESTHESIA

PATIENT QUESTIONNAIRE

Date

Please circle:
Have you had your COVID vaccine? ☐1 dose ☐2 doses ☐NO

1. List all your previous Surgeries ☐I have had no Surgeries

Procedure	Hospital	Year

			Don't Know
2. Have you or any family members (including aunts, uncles & cousins) had an adverse reaction to anaesthetic drugs? e.g. malignant hyperthermia	☐Yes	☐No	
3. Have you ever had heart problems? (if yes, please circle which one) Heart Attack, Angina, Rheumatic Fever, Heart Murmur, Rhythm problems, Other:	☐Yes	☐No	
4. Have you ever had high blood pressure?	☐Yes	☐No	
5. Have you had chest or breathing problems? (if yes, please circle which one) Asthma, Emphysema, Bronchitis, Tuberculosis, Pneumonia, Sleep Apnea, Other:	☐Yes	☐No	
6. Have you had an injury or do you have a condition affecting your neck or jaw?	☐Yes	☐No	
7. Have you had Hepatitis A, B or C? (if yes, please circle which one)	☐Yes	☐No	
8. Have you had or do you have diabetes? (if yes, please circle) Diet Controlled, Oral Medication, Insulin Dependent	☐Yes	☐No	
9. Do you have or have you had kidney problems, stroke, epilepsy?	☐Yes	☐No	
10. Have you had a blood transfusion in the last 3 months?	☐Yes	☐No	
11. Do you have bleeding problems?	☐Yes	☐No	
12. Do you have false teeth, caps, crowns, loose teeth, contact lenses, hearing aid? (if yes, please circle which ones)	☐Yes	☐No	
13. Do you smoke? (if yes, amount per week)	☐Yes	☐No	
14. Do you drink alcohol? (if yes, amount per week)	☐Yes	☐No	
15. Do you have a history of complications during pregnancy? e.g. toxemia ☐N/A	☐Yes	☐No	
16. Have you taken steriods in the last 6 months? (not including Cortisone Injections)	☐Yes	☐No	
17. Are you allergic to anything (medications, latex, food, environmental, other)? (if yes, please list)	☐Yes	☐No	

18. List current regular medications you are taking, including over-the-counter drugs.

19. List serious illnesses you have had in your life and the approximate year.