CAMBRIDGE MEMORIAL HOSPITAL
700 Coronation Blvd.,
Cambridge, ON N1R 3G2
519-621-2330

Patient Sticker

Pre-Anesthetic Patient Questionnaire

Date: (dd/mm/yyyy)_____ Age:_____

Surgery:_____

Name of Person Completing this Form:_____

Relationship to Patient:_____

General Questions	Yes	No
• Have you ever had an anesthetic in the past? ○ Spinal/Epidural ○ General	○	○
Surgeries and Dates		
_____		
_____		
_____		
• Have you or a relative had any problems with anesthesia, such as		
◦ Malignant Hyperthermia?_____	○	○
◦ Pseudocholinesterase Deficiency?	○	○
◦ Breathing Problems?_____	○	○
◦ Difficulty with insertion of the anesthesia breathing tube?	○	○
◦ Other_____	○	○
• Do you Smoke?	○	○
◦ Number of cigarettes a day_____		
◦ Number of years_____		
• If you smoked in the past, when did you stop smoking?_____		
• Do you drink alcohol?	○	○
◦ Number of drinks a day_____		
◦ Number of drinks a week_____		
• Do you use recreational drugs or street drugs or marijuana?	○	○
◦ Type_____		
◦ Amount_____		
◦ How often?_____		
• Have you taken Cortisone, Prednisone, or other steroids in the last 3 months?	○	○
• Could you be pregnant right now?	○	○
• Do you have any:	○	○
○ capped or loose teeth ○ partial or full dentures ○ dental implants ○ dental veneers		
• Do you have any orthopedic/metal implants?	○	○
Respiratory Questions		
• Have you had a cold, flu or chest infection in the last month?	○	○
• Do you have a cough with sputum?	○	○
• Do you have any trouble with your breathing?	○	○
Have you ever been diagnosed with		
○ Asthma ○ Tuberculosis ○ Emphysema ○ COPD		
• Do you use home oxygen?	○	○
• Do you have a Respirologist?	○	○
◦ Name_____		
• Do you have excessive snoring or obstructive sleep apnea?	○	○
• Is your obstructive sleep apnea treated with:	○	○
○ CPAP? ○ BIPAP? What are the settings?_____		
Cardiovascular Questions		
• Do you have high blood pressure?	○	○
• Have you ever had: ○ Angina ○ Heart Attack ○ Heart surgery ○ Carotid surgery	○	○
• Do you have an irregular heart beat?	○	○
• Do you have: ○ a Pacemaker ○ an Implanted Defibrillator	○	○

	Yes	No
• Do you have a heart murmur?	O	O
• Have you ever had congestive heart failure?	O	O
• Do you have a Cardiologist? Name:_____	O	O
• Can you walk 2 blocks without stopping?	O	O
• Do you have problems with the circulation in your legs (peripheral vascular disease)?	O	O
Gastrointestinal Questions		
• Have you ever had liver problems such as Hepatitis?	O	O
• Do you have: O frequent heartburn O stomach ulcers O hiatus hernia?	O	O
• Do you have: O a colostomy O an ileostomy?	O	O
Renal Questions		
• Have you ever had kidney disease?	O	O
• Are you a dialysis patient? O Peritoneal O Hemodialysis	O	O
Endocrine Questions		
• Do you have Diabetes?	O	O
• How is your Diabetes managed? O Diet O Oral Medications O Insulin		
• Do you have thyroid problems?	O	O
Neurological/Musculoskeletal Questions		
• Have you ever had seizures? If yes, when was your last seizure?_____	O	O
• Have you ever had a stroke or TIA? If yes, when?_____	O	O
• Do you have any neurological or muscular disorders? Type_____	O	O
• Do you have: O Osteoarthritis O Rheumatoid Arthritis O Other_____	O	O
• Have you ever been treated for a psychiatric illness? Type:_____	O	O
Hematological Questions		
• Have you ever been diagnosed with a bleeding disorder?	O	O
• Are you anemic?	O	O
• Have you ever had a blood clot in your legs or lungs?	O	O
• Do you have: O thalassemia O sickle cell disease	O	O
• Have you taken a blood thinner in the last month? Type:_____	O	O
• When did you stop taking the blood thinner?_____		
• Will you accept blood products if necessary?	O	O
• Have you ever been treated for cancer?	O	O
• Type_____		
• When_____		

Allergies and Medications

List All Allergies	Type of Reaction
_____	_____
_____	_____
_____	_____

List All Medications (include over the counter medicine, inhalers, patches, drops, vitamins, minerals, supplements, herbal products) Please attach a separate sheet if more space is needed.

Medication Name	Dose	How Often	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is there anything we need to know about you to help make your hospital stay the best possible experience for you?

Completed By:_____ Date:_____ Signature:_____