WRHN
Waterloo Regional Health Network

PRE-ANESTHETIC QUESTIONNAIRE

Patient Identification Label (Affix)

Preferred Name: _____ Height: _____ Weight: Lbs/kgs _____ BMI: _____ Age: _____

	Body System Review *(Do you have any of these medical conditions? Please check yes or no or circle, if appropriate)*	Yes	No	Any Comments
Heart and Circulation	High blood pressure			
	Heart attack Date:_____			
	Chest pains / Angina Frequency: _____			
	Heart murmur / Valvular heart disease / History of rheumatic fever			
	Blood clots DVT(legs) / PE(lungs) *(please circle)*			
	Congestive heart failure			
	Atrial fibrillation / Irregular pulse / Palpitations			
	History of angiogram / Stent insertion / Heart surgery *(please circle)*			
	Pacemaker or I.C.D. When Inserted:_____ Last Checked: _____			
	Peripheral vascular disease			
Respiratory / Lungs	Asthma, wheezing, chronic cough			
	Recent chest cold or pneumonia less than 1 month ago			
	Emphysema, COPD □ Home Oxygen			
	Diagnosed or probable obstructive sleep apnea (OSA) (breath-holding while asleep)			
	• Regular CPAP machine use □ Yes □ No			
	Activities limited by shortness of breath – stairs or walking one block			
	Emergency Department or ICU admission for breathing trouble (Lifetime)			
	Tuberculosis (T.B.) / Exposure			
	Have you ever smoked/Vaping □ Yes □ No Quit Date:			
	Currently smoke/Vaping? Packs per day average ____Number of years ____			
Neurologic	Stroke or Transient Ischemic Attack (TIA)"mini-stroke" Deficits / Location: _____			
	Seizure / Epilepsy Date of last seizure:_____			
	Vertigo, balance disorders, headaches *(please circle)*			
	Neuromuscular disease (i.e. MS, CP, Myasthenia, ALS, Parkinson's) *(please circle)*			
	Paraplegia / Quadriplegia / Other mobility issues? □ Wheelchair dependent			
	Chronic pain syndrome Regular narcotic / opioid usage □ Yes □ No			
Endocrine	Diabetes Date Diagnosed: _____□ Diet □ Pills □ Insulin			
	Thyroid gland problems			
	Pituitary or adrenal gland disease			
	Autoimmune Disease (i.e. Sjogren's, Lupus, Psoriasis, Rheumatoid, Raynaud's)			
	Recent steroid use (e.g. prednisone) Date: _____			
Gastro-intestinal / Renal	Kidney problems / Transplant / Dialysis PD / Hemo days: ___/___/___			
	Hepatitis / Liver disease / Jaundice			
	Acid reflux / Heartburn Treated with medications □ Yes □ No			
Other	Gout or Osteoarthritis *(please circle)* Location:_____			
	Mental health problems □ Depression □ Anxiety □ Other _____			
	Blood problems (i.e. Anemia / Low platelets / Sickle-cell disease / HIV)			
	Taking blood thinners – Reason:_____			
	History of cancer – Location:_____			
	Chemotherapy / Radiotherapy Date of treatment:			
	Glaucoma / Eye problems / Hearing loss □ Glasses □ Hearing aids			

See over →

Teeth: *(please check)* □ Own □ Wires □ Dentures □ Caps / Crowns □ Partial plate □ Loose / Poor condition

List all previous operations and approximate year: *(Please attach list if space is insufficient)*	
1.	4.
2.	5.
3.	6.

Have you ever been hospitalized for an illness not requiring surgery? Explain:

Do you have any health problems that need further explanation or testing? Explain:

Do you or your close relatives have a history of malignant hyperthermia (MH) or pseudocholinesterase deficiency? □ No □ Yes

Have you had a serious problem with previous anesthesia? (i.e. difficult intubation, vomiting, shivering, unplanned admission, post-operative confusion / delirium) □ No □ Yes
Explain: _____

Medications you are currently taking *(please include over-the-counter, herbal and non-prescription meds)*

	Name of Medication *(Please attach list if space is insufficient)*	**Dose (Amount)**	**Times of the day taken**
1			
2			
3			
4			
5			
6			
7			
8			

Pharmacy Name: _____ Phone number: _____

Pharmacy Location:

Medication **Allergies** *(List drug name and reaction)* *(Please attach list if space is insufficient)*

Drug	**Reaction**

Are you allergic to latex / rubber products? □ No □ Yes Reaction: _____

Additional Information	**Yes**	**No**
Do you drink alcohol regularly?		
• How many drinks / day? _____ or How many drinks / week? _____		
Have you ever taken street / recreational drugs? If currently, what? _____		
Explain if you have ever had problems with addictions _____		
Do you smoke marijuana? If YES, how much _____		
Have you ever received a blood transfusion?		
Would you accept a blood transfusion if deemed medically necessary?		
Do you have reason to believe you might be pregnant?		

Procedure: _____ Patient's Signature: _____

Surgeon's Name: _____ Date: _____