GRAND RIVER HOSPITAL
Advancing Exceptional Care

PRE-ANESTHETIC QUESTIONNAIRE

St.Mary's GENERAL HOSPITAL

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: ______________

Lifestyle Choices	**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?		

Procedure: ____________________ Patient's Signature: ____________________

Surgeon's Name: ____________________ Date: ____________________

Questionnaire completed by:__________________ Relationship to patient: ______________