Trillium Health Partners

PREOPERATIVE QUESTIONNAIRE

TO BE COMPLETED BY PATIENT
The information you supply below assists in the development of your anesthesia care plan. Please complete this questionnaire accurately and completely by answering Yes or No to all of the questions below. Return the questionnaire to your care team.

Check Yes or No	Yes	No	Comments
Have you ever had a problem with local or general anesthetics?			
Has anyone related to you ever had a problem with an anesthetic? (eg. Malignant Hyperthermia, pseudocholinesterase deficiency)			
Do you have difficulty opening your mouth fully?			
Do you have a history of a difficult airway or difficult intubation?			
Cardiovascular	**Yes**	**No**	**Comments**
Do you have a history of heart problems? (eg heart attack, angina, blockages, angioplasty, stent, valve problems, heart surgery, congestive heart failure)			
Do you have or have you ever had an irregular heart beat? (atrial fibrillation, SVT, WPW)			
Do you wake up at night because you can't catch your breath?			
Do you get chest pain or breathless after climbing one flight of stairs or walking two blocks on a flat surface?			
Do you have high blood pressure that is difficult to control?			☐ on medication
Do you have a pacemaker or implantable cardiac defibrillator (ICD)?			
Respiratory	**Yes**	**No**	**Comments**
Do you have asthma that is difficult to control?			
Do you have chronic bronchitis, COPD or emphysema?			
Do you use oxygen at home?			
Have you been told that you stop breathing when you are asleep or have you been diagnosed with Obstructive Sleep Apnea?			☐ Use CPAP ☐ Don't use CPAP
GI/Renal	**Yes**	**No**	**Comments**
Do you have or require AV fistula, dialysis, kidney transplant?			
Do you have liver disease or a history of hepatitis?			
Endocrine	**Yes**	**No**	**Comments**
Do you have diabetes requiring insulin?			
Do you have pituitary or adrenal disease?			
Neuro	**Yes**	**No**	**Comments**
Do you have disease of the muscles?			
Hematology	**Yes**	**No**	**Comments**
Do you have a bleeding disorder?			
Have you had an organ or bone marrow transplant?			
Other	**Yes**	**No**	**Comments**
Do you have a chronic pain disorder requiring opioid treatment?			
Have you had radiation treatment to the head or neck?			
Do you have arthritis of the neck (rheumatoid or osteoarthritis)?			

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Additional Information				
	Check Yes or No	**Yes**	**No**	**Comments**
Respiratory	Have you had pneumonia in the last 3 months?			
	Have you ever had tuberculosis?			
	Do you smoke? ☐ Yes ☐ No If you stopped smoking, when did you quit? _____ years ago			Number/day: _____ Number of years:
	Do you use inhalers (puffers)?			
	Have you ever been admitted to the hospital due to your breathing?			
	Do you have asthma?			
GI/Renal	Do you have problems with your kidney function?			
	Do you have stomach ulcers, a hiatus hernia or heartburn (acid reflux)?			
	Are you easily nauseated or get motion sickness easily?			
	Do you have any bowel disease?			
Endocrine	Do you have **non-insulin** dependent diabetes?			Controlled with: ☐ Diet ☐ Pills
	Do you have a history of thyroid disease? ☐ Hypo or Under active ☐ Hyper or Over active			
	Could you be pregnant at this time?			
Neuro	Have you had seizures or epilepsy?			
	Have you had a stroke or TIA?			
	Do you have dementia?			
Hematology	Are you on any blood thinners? (e.g., warfarin, coumadin, plavix, dabigatran, pradax)			
	Are you at risk for sickle cell disease?			
	Have you ever had a blood clot in your legs or lungs?			
	Have you had a reaction to a previous blood transfusion?			
	Do you have an objection to receiving blood products?			
	Do you have any blood borne infectious diseases? (eg HIV or Hep B, Hep C)			
Other	Have you had radiation treatment (other than to the head or neck)?			
	Have you had cortisone, prednisone or steroids in the last year?			
	Do you have rheumatoid or osteoarthritis?			
	Have you had a Chest X-ray/EKG/Echo/Stress test in the last 5 years?			If YES, please bring a copy to your appointment
	Do you have high blood pressure or take medication for high blood pressure?			
	How much alcohol do you drink? _____ glasses per week			
	Do you use recreational drugs?			

Do you have any other illness, limitations or any other concerns we should know about?

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List any previous operations/hospitalizations	Dates
1	
2	
3	
4	
5	

List Allergies and reactions:

1	3
2	4

Medication Name (Including over the counter medications/vitamins/supplements)	Dosage	How often do you take it?	***DAY SURGERY USE ONLY*** Date/Time Last Taken
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Patient Name or Name of Substitute Decision Maker

Signature

Date

DAY SURGERY:	
HCP Name:	
HCP Signature:	
HCP Designation:	

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