



**Halton Healthcare Services  
Georgetown / Oakville**

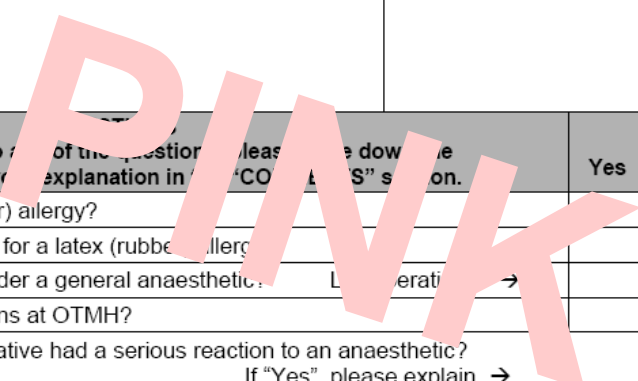
**Dept. of Anaesthesia**

**PRE-ANAESTHETIC QUESTIONNAIRE**

PLEASE STAMP BELOW

List All Medications, Inhalers, or Eye Drops You Are Currently Using

List Any Allergies



If you answer "Yes" to any of the questions, please write down the question number and your explanation in the "COMMENTS" section.	Yes	No	COMMENTS
1a. Do you have a latex (rubber) allergy?			
1b. Have you ever been tested for a latex (rubber) allergy?			
2a. Have you ever been put under a general anaesthetic? List anaesthetic →			
2b. Have you had any operations at OTMH?			
3. Have you, or any blood relative had a serious reaction to an anaesthetic? If "Yes", please explain →			
4. Do you or any blood relative have malignant hyperthermia?			
5. Do you wear dentures?			
6. Are there any teeth in your mouth that are loose or capped?			
7. <input type="checkbox"/> Do you, or <input type="checkbox"/> did you smoke? When did you quit? Date:			
8. Do you have asthma? List asthma medications <i>above</i> under "Medications".			
9. Have you taken Prednisone or any steroids within the last year?			
10. Have you had a cold or chest infection recently?			
11. Have you ever had tuberculosis, sarcoid, lymphoma or any lung problem?			
12. Have you ever had a heart attack? Date:			
13. Have you had heart surgery or an angioplasty? Date:			
14. Do you have angina, or get chest pain with activity? Date of last chest pain:			
15. Do you see a heart specialist? Name of specialist:			
16. Do you have a pacemaker? When was it last checked? Date:			
17. Do you have high blood pressure?			
18. Have you ever had a stroke? Date:			
19. Have you ever had severe muscle weakness or paralysis of any part of your body?			
20. Do you take Aspirin, Ticlid, or Coumadin on a regular basis?			
21. Do you bruise or bleed easily?			
22. Do you have a hiatus hernia? If you lie flat, does food or fluid from your stomach come up to your throat?			
23. Have you ever had yellow jaundice or hepatitis?			
24. Do you drink alcohol daily?			
25. Do you use recreational drugs?			
26. Do you have any problems with your kidneys?			
27. Are you on dialysis?			
28. Do you have diabetes?			
29. Do you take insulin or diabetic pills?			
30. Do you have epilepsy? Have you ever had seizures? Date of your last seizure:			
31. Do you have rheumatoid or osteoarthritis?			
32. Have you ever had a back or neck injury? If you have problems presently, please explain →			
33. Do you have any problems with your blood, or do you have sickle cell anemia?			

**Patient Signature**

**Date**

