Dr. Gino Gizzarelli*

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ANAESTHESIA *for* DENTISTRY

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Pre-Anaesthesia Questionnaire (Adult)

Date of Birth: _____

Name _____ Date _____

		Yes	No	Not sure
1.	Do you have any health problems or concerns presently? _____	☐	☐	☐
2.	Has there been ANY change in your general health in the past year? When did you last have a complete physical exam? (month)_____ (year) ___ How often do you see your family doctor or specialist? Every_____	☐	☐	☐
3.	Have you ever been in hospital for treatment? _____ When, where and why? _____	☐	☐	☐
4.	Have you ever had general anaesthesia or surgery? _____ When, where and why? _____ Were there any problems with the anaesthesia? _____	☐	☐	☐
5.	Have you or any of your family relatives had problems with anaesthesia? Please explain. Were any tests done?	☐	☐	☐
6.	Do you have a drug allergy? What drug? What year? What happened? (Circle) rash breathing problems/wheezing swelling	☐	☐	☐
7.	Do you have any other allergies (e.g. latex)? _____	☐	☐	☐
8.	Do you take ANY medications (including puffers and birth control pills)? Please list or bring a list of all of your medications or bring them to the office: Name Dose	☐	☐	☐
9.	Do you use or take ANY non-prescription remedies (including herbal remedies)? Name	☐	☐	☐
10.	Have you taken a cortisone (steroid) type drug orally in the past year? When? How long were you taking it for?	☐	☐	☐
11.	Do you or any of your relatives have a bleeding problem?	☐	☐	☐
12.	Do you have or have had any difficulty breathing through your nose?	☐	☐	☐
13.	Do you have any nose bleeds? If so how many per week? _____	☐	☐	☐
14.	Do you have or have had any difficulty breathing while sleeping at home?	☐	☐	☐
15.	Can you walk up 2 flights of stairs or 2 city blocks quickly without resting?	☐	☐	☐