

Pre-Anaesthesia Questionnaire (Adult) cont'd

Name _____

Age _____

16. Do you have or have you ever had any of the following?

	Yes	No	Not Sure		Yes	No	Not Sure
Heart murmur				Fainting spells, dizziness			
Heart attack				Diabetes			
Chest pain or angina				Thyroid problems			
Shortness of breath lying down				Adrenal gland problems			
Swollen ankles				Hepatitis			
Heart pacemaker/defibrillator				Liver disease / Jaundice			
Irregular heart beat/arrhythmia				Anemia (including sickle cell)			
High blood pressure				Blood disorders/transfusions			
Congenital heart disease				Bleeding (Coagulation) disorders			
Damaged/abnormal heart valves				Stomach ulcers/ Acid Reflux			
Rheumatic fever				Bone, joint, or muscle problems			
Kidney disease				Artificial joints – hips, knees			
HIV, AIDS or STD				Arthritis			
Malignant hyperthermia				Depression / anxiety			
Pseudocholinesterase deficiency				Vision problems / glaucoma			
Cancer / Chemotherapy				Mentally disabled			
Sleep apnea				Cerebral palsy			
Asthma				Autism or Down's syndrome			
Emphysema / Bronchitis				WOMEN:			
Cystic fibrosis / Tuberculosis				Are you pregnant?			
Epilepsy				Are you a nursing mother?			
Stroke				Any problems with menstruation?			

- | | Yes | No | Not sure |
|--|--------------------------|--------------------------|--------------------------|
| 17. Do you ever have episodes of blurred vision or black spots, or experience weakness or paralysis on one side of your body, arms, legs or face? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Do you have any problems opening your mouth wide or moving your neck fully? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you ever had surgery, radiation or chemotherapy treatment for a tumour or cancer? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you smoke, if so how much? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Do you drink more than 5 alcoholic beverages per week? Number/week _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you have a history of alcoholism or drug dependence? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Have you taken any "recreational" drugs in the past year such as marijuana, LSD, PCP, cocaine, crack, 'crystal meth', codeine, oxycodone or other drugs? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Do you have ANY disease, condition or problem not listed above? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. How much do you weigh? _____ Height _____ | | | |
| 26. Additional comments: _____ | | | |

Signature: _____	Date: _____
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