## Patient Pre-Operative Anesthetic Questionnaire with Physician Pre-Operative Assessment

Date (MM/DD/YYYY):

Surname:			MSP#:
Given Names:			Gender:  Female  Male
Date of Birth (N	MM/DD/YYYY	Y):	
Post-Procedure	Pick up Name	and Phone number:	
-	J		eight below. If you are unsure about your
BMI, a staff me	ember will be h	happy to calculate it for y	ou.
Height:	Weight:	BMI:	
The questions b	below are for it	nfection control at our E	ndoscopy Unit. Thank you for your
cooperation.			
Have you recen	tly been hospit	calized for more than 72 h	ours (excluding Emergency Room)?
Yes No			
If so, please spe	cify the reason	n:	
Have you ever l	been diagnose	d with an antibiotic-resis	tant organism (ARO) such as:
Methicillin-resi	stant Staphylo	coccus aureus (MRSA)	Yes 🔲 No 🔲
Vancomycin-Resistant Enterococci (VRE)			Yes 🔲 No 🔲
Tuberculosis (T	B)		Yes 🔲 No 🔲
• Have you red	ceived health c	are in a facility outside of	f Canada in the last 12 months? Yes \( \square\) No \( \square\)
• Have you ev	er been admitte	ed to, or spent more than	12 continuous hours as a patient in, any health
care facility	in the last 12 m	nonths? Yes 🗌 No 🗌	
• Do you have	HIV/AIDS?	Yes No No	
Please answer t	the questions b	pelow by checking off "Yo	es" or "No." If you need to expand, feel free
to do so in the s	pace below the	e question.	
Do you have an	y food/drug/la	tex allergies or sensitivitie	es? If so, list below. No 🗌
Yes Allerg	gic to:	Reaction:	
Allerg	ic to:	Reaction:	
Allerg	ic to:	Reaction:	
Allargi	c to:	Reaction:	

Have you had a cough, cold or sore throat in the la	Yes  No	
Do you take aspirin (or a similar drug)?	Yes 🗌 No 🗌	
Do you take any medications? (prescribed, over-th	Yes 🗌 No 🗌	
List of Medications (Names Only):	,	
Dist of Medications (Names omy).		
<del></del>		
Are you a current smoker, or were you a regular st	moker in the past?	Yes 🗌 No 🗍
Do you use eye drops or nose drops?	Yes 🗌 No 🗌	
Do you wear contact lenses?	Yes 🗌 No 🗌	
Do you have dentures or bridges?		Yes 🗌 No 🗌
Are your front teeth capped?	Yes 🗌 No 🗀	
Are any teeth loose, chipped or bad?	Yes 🗌 No 🗌	
Do you have an alcoholic drink more than once a	Yes 🗌 No 🗌	
Have you, or your relatives had an unexplained or	serious complication	
during surgery or anesthesia?		Yes 🗌 No 🗌
Have you had any previous procedures done before	re? If so, specify below	v. Yes 🗌 No 🗌
Is it possible you may be pregnant?		Yes 🗌 No 🗌
Have you had or still have any of the following p	oroblems? (Please ched	ck if applicable)
Ulcer, Hiatus Hernia	Anemia	
Blood Clots	Sickle Cell A	nemia
Swollen, Sore Legs	Prolonged Bl	eeding
Bronchitis	Thyroid Dise	
Emphysema	Persistent Inc	
Phlegm	Back Problem	ns
Pneumonia, Lung Problems	Arthritis	
Asthma, Wheezing	Weakness W. II.	1
☐ Shortness of Breath ☐ Heart Condition	Walking Prob	olems
	Blackouts Stroke	
☐ High Blood Pressure ☐ Low Blood Pressure	Dizziness	
Heart Attack	Blindness	
Rheumatic Fever	Deafness	
Heart Murmur	Epilepsy	
Palpitations	Meningitis/Po	olio
Pacemaker	Headaches	
Chest Pain, Angina	Glaucoma	
Kidney Problems	Nervous Disc	order
Hepatitis, Liver Problems	Cancer	
Bruise or Bleed Easily	Cold Sores/H	lerpes

☐ Venereal Disease ☐ Prednisone Treatment	Any other problems:					
Do you have any major fears regarding your proced	ure?	Yes No No				
I have read and understood the above questionnaire and certify that the answers given by me						
(or a representative for me) are correct to the best of my knowledge.						
Patient signature:						