

Dr. Gino Gizzarelli*

BScPhm, DDS, MSc (Dental Anaesthesia)

ANAESTHESIA for DENTISTRY

(416) 839-4777

Pre-Anaesthesia Questionnaire (Adult)

Date of Birth: _____

Name _____	Date _____	Yes	No	Not sure
1. Do you have any health problems or concerns presently? _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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 _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever been in hospital for treatment? _____ When, where and why? _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had general anaesthesia or surgery? _____ When, where and why? _____ Were there any problems with the anaesthesia? _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you or any of your family relatives had problems with anaesthesia? Please explain. Were any tests done?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have a drug allergy? What drug? What year? What happened? (Circle) rash breathing problems/wheezing swelling		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have any other allergies (e.g. latex)? _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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 _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you use or take ANY non-prescription remedies (including herbal remedies)? Name _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you taken a cortisone (steroid) type drug orally in the past year? When? _____ How long were you taking it for? _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you or any of your relatives have a bleeding problem?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you have or have had any difficulty breathing through your nose?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you have any nose bleeds? If so how many per week? _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you have or have had any difficulty breathing while sleeping at home?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Can you walk up 2 flights of stairs or 2 city blocks quickly without resting?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>