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?	☐	☐	☐
18.	Do you have any problems opening your mouth wide or moving your neck fully?	☐	☐	☐
19.	Have you ever had surgery, radiation or chemotherapy treatment for a tumour or cancer?	☐	☐	☐
20.	Do you smoke, if so how much? _____	☐	☐	☐
21.	Do you drink more than 5 alcoholic beverages per week? Number/week _____	☐	☐	☐
22.	Do you have a history of alcoholism or drug dependence?	☐	☐	☐
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?	☐	☐	☐
24.	Do you have ANY disease, condition or problem not listed above? _____	☐	☐	☐

25. **How much do you weigh?_____Height_____**

26. Additional comments:_____

Signature: **Date:**