HANOVER & DISTRICT HOSPITAL

PRE-ANAESTHETIC QUESTIONNAIRE

Patient Label

Please Print Name: ____

Pre-op Visit ❒ Phone Pre-op ❒

Complete and explain if necessary	Yes		No
1. Are you allergic to anything?	❒		❒
If yes, list and reaction: ______________________________			
2. Have you had a recent illness:	❒	____________	❒
3. Have you had a sore throat, a cold or the flu?	❒	____________	❒
4. Have you had a general anaesthetic before?	❒	____________	❒
5. Have you had problems with an anaesthetic in the past?	❒	____________	❒
6. Has anyone related to you ever had an anaesthetic with a Serious complication? E.g. Malignant Hyperthermia	❒	____________	❒
7. Is there a history of patient or family allergy to latex?	❒	____________	❒
8. Have you taken Aspirin in the last week?	❒	____________	❒
9. Could you be pregnant?	❒	____________	❒
10. Do you smoke or vape? How often or many per day?	❒	____________	❒
11. Do you use recreational drugs? What? How Much?	❒	____________	❒
12. Do you use medical marijuana or its' derivatives (CBD oil)	❒	____________	❒
Do not use any medical/recreational drugs 48h prior to surgery			
13. Do you use alcohol? How much?	❒	____________	❒
14. Do you have a history of MRSA or CPE?	❒	____________	❒
15. Have you received any blood or blood products recently?	❒	____________	❒
If yes, date of transfusion: ______________________________			

16. Have you had, or do you have? (√ if yes)

❒ Irregular heart beat	❒ Blood clots (phlebitis)	❒ Asthma
❒ Pacemaker	❒ Stroke	❒ Shortness of breath/COPD
❒ Heart disease	❒ Fainting	❒ Pneumonia
❒ Heart attack	❒ Anemia (low blood)	❒ Hiatus hernia/reflux
❒ Angina	❒ Migraine headaches	❒ Kidney problems
❒ High blood pressure	❒ Diabetes	❒ Epilepsy or seizures
❒ Mitral valve prolapse	❒ Thyroid problems	❒ Arthritis
❒ Sleep Apnea/CPAP	❒ Emphysema /bronchitis	❒ Jaundice
❒ Bleeding problems	❒ Tuberculosis (T.B.)	❒ Rheumatic fever
❒ HIV/Hepatitis		❒ Other ____________

(….continued over page)

Please turn over and complete page 2

Do you take any pills (vitamins or supplements) or medication on a regular basis? Yes ☐ No ☐

List below: (include prescription and over the counter drugs, eye drops, inhalers and insulin)

Drug	Amount	How often	Purpose	To be completed by Nurse Taken O.R. day?	Init.
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

Any previous surgery or procedures i.e. scopes etc?	Year

What operation are you having? ____________________

Patient's signature: ____________________ Date: ____________

(Relationship if other than patient): ____________________

Reviewed by: ____________________ ____________ Date: ____________

Status