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. Do you take Ozempic (semaglutide), Wegovy, Rybelsus, Trulicity, Victoza or Mounjaro? If yes, please HOLD FOR 7 DAYS	☐	_____	☐
10. Could you be pregnant?	☐	_____	☐
11. Do you smoke or vape? How often or many per day?	☐	_____	☐
12. Do you use recreational drugs? What? How Much?	☐	_____	☐
13. Do you use medical marijuana or its' derivatives (CBD oil) **Do not use any medical/recreational drugs 48h prior to surgery**	☐	_____	☐
14. Do you use alcohol? How much?	☐	_____	☐
15. Do you have a history of MRSA or CPE?	☐	_____	☐
16. Have you received any blood or blood products recently? If yes, date of transfusion: _____	☐	_____	☐

17. 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	☐ Glaucoma	☐ 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): _____

Date:

Reviewed by: _____ _____ _____

Status