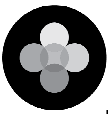
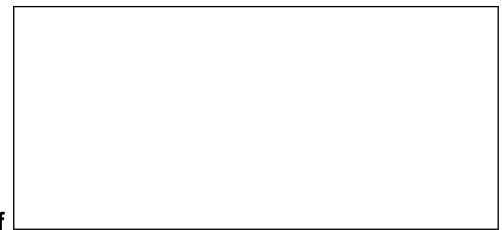


Lakeridge Health

Patient Health Questionnaire
Department of Anaesthesia



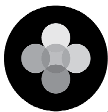
Complete these forms in the Surgeon's Office and return to the office staff
PLEASE PRINT CLEARLY

Primary diagnosis				Patient Name	
Type of operation				Family Physician	
Date of operation				Age	Phone Number
Surgeon	Height	(ft/in)	(cm)	BMI	Completed by nurse
	Weight	(lbs)	(kg)		Last meal ____ last drink ____

Have you ever had: General anaesthetic (asleep for surgery) ☐ Epidural ☐ Spinal ☐ Local ☐ None ☐		
Have you or a relative had any reaction/problems with past anaesthetics?	Yes	No
(eg. Malignant Hyperthermia, Pseudocholinesterase deficiency, Anaphylactic reaction)		
If yes, please specify:		
Do you smoke? How many cigarettes do you smoke in a day? ________ never smoked ☐ quit ____ yrs ago ☐		
Any cough? Type of cough wet ☐ dry ☐	Yes	No
Do you have any allergies? (latex, medication, food) If yes please list. Include the type of reaction.	Yes	No
Are you pregnant or think you might be pregnant? Date of last menstrual period	Yes	No
Do you have any loose teeth, caps or crowns, bridges, dentures or other dental appliances?	Yes	No
If yes, please specify		
Do you take or have you ever taken any **addicting or recreational drugs?**	Yes	No
If yes, please list:		
How much **alcohol** do you drink in a week? ____ glasses ________ type		

Please indicate comments and date of occurrence for each of the following:

Do you or have you ever had:	Yes	No	Date
Angina or chest pain			
Chest pain climbing one flight of stairs or at night			
Heart attack or heart failure			
High blood pressure			
Palpitations or irregular pulse, heart murmur			
Pacemaker or internal defibrillator (ICD)			
Bypass surgery, angioplasty or stent			
Valve replacement or heart transplant			
Stroke or TIA			
Peripheral Vascular Disease: eg. DVT, phlebitis, blood clot, aortic aneurysm			
Asthma			
Chronic Bronchitis, emphysema, COPD			
Sleep apnea (heavy snoring, choking, use of CPAP)			
Shortness of breath climbing one flight of stairs or at night			
Tuberculosis			
Other lung problems			
Diabetes			
Liver disease/Hepatitis			



Lakeridge Health

Patient Health Questionnaire

Please indicate comments and date of occurrence for each of the following:	Yes	No	Date
Sickle cell disease/trait or family history of anemia			
Easy bleeding or bruising			
Thyroid problems			
Muscular dystrophy, epilepsy, seizure, polio			
Kidney problems			
Acid reflux or frequent heartburn/ulcer/hiatus hernia			
Rheumatoid arthritis/ankylosing spondylitis			
Chronic neck/nack or muscle injury or problems			
Inability to cooperate with care providers during stressful situations			
Have you taken Prednisone/steroid medication in the last 6 months?			
Have you ever had a blood transfusion?			
Have you ever had any serious illness not mentioned above? (cancer, chemotherapy)			
Please list			

Please list past surgeries and dates

Surgery	Date	Surgery	Date

What is the name of the specialist who looks after your medical condition?

Cardiologist ____________ Internist ____________ Respirologist ____________

Please list **ALL MEDICATIONS** you take at home including over–the–counter drugs, puffers, insulin and herbal supplements:

Drug name and dose (indicate time of day taken)	Anaesthesia initial if drug is to be taken	Drug name and dose (indicate time of day taken)	Anaesthesia initial if drug is to be taken

Completed by:	Date
Reviewed by Anaesthesiologist:	Date
Reviewed by Nurse:	Date