Dr. Andrew Tortorella

ANAESTHESIA FOR DENTISTRY

(905) 356-7822

Pre-Anaesthesia Questionnaire (Adult) Date of Birth: _____

Name _____ **Date** _____

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

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Do you have or 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?	◯	◯	◯
24.	Have you taken any " recreational" drugs in the past year such as marijuana, LSD, PCP, cocaine, crack, 'crystal meth', codeine, oxycodone or other drugs?	◯	◯	◯
28.	Do you have ANY disease, condition or problem not listed above?	◯	◯	◯

Please explain:_____

29. **How much do you weigh?** _____ Height? _____

30. Additional comments: _____

Signature: **Date:**