TORONTO IMMUNE & DIGESTIVE HEALTH INSTITUTE

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PRE-ANESTHESIA QUESTIONNAIRE

Please submit completed questionnaire by fax (647-812-2114) or email (reception@tidhi.ca) at least 14 days prior to the scheduled procedure.

Date of Procedure (MM/DD/YY)**:**

Name *(Last, First, M.I.):*		**DOB** (MM/DD/YY)**:**	
OHIP #:	**Version Code:**	**Weight:**	**Height:**
Emergency Contact Name:	**Relationship:**	**Phone:**	

MEDICAL HISTORY

Cardiac Health		
Angina	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No
Myocardial Infarction	☐ Yes	☐ No
Atrial Fibrillation	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No
Cardiac Valve Disorders	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Stent/Angioplasty	☐ Yes	☐ No
Other:		

Blood Health		
Anemia	☐ Yes	☐ No
Sickle Cell Trait	☐ Yes	☐ No
Sickle Cell Anemia	☐ Yes	☐ No
Bleeding Disorder	☐ Yes	☐ No
DVT or PE	☐ Yes	☐ No
Aneurysm	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Other:		

Respiratory Health		
Asthma	☐ Yes	☐ No
COPD	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Sleep Apnea ☐ CPAP	☐ Yes	☐ No
Other:		

Endocrine and Metabolic Health		
Diabetes ☐ Type I ☐ Type II	☐ Yes	☐ No
Thyroid Disease *name:*	☐ Yes	☐ No
Other:		

Gastrointestinal Health		
Heartburn or GERD	☐ Yes	☐ No
Hiatus Hernia	☐ Yes	☐ No
Liver Disease *name:*	☐ Yes	☐ No
Inflammatory Bowel Disease	☐ Yes	☐ No
Difficulty Eating or Swallowing	☐ Yes	☐ No
Nausea or Vomiting	☐ Yes	☐ No
Other:		

Neuro and Musculoskeletal Health		
Dementia	☐ Yes	☐ No
Alzheimer's disease	☐ Yes	☐ No
Migraine	☐ Yes	☐ No
Vertigo	☐ Yes	☐ No
Neuropathy	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No
Spinal Stenosis	☐ Yes	☐ No
Osteoarthritis	☐ Yes	☐ No
Rheumatoid Arthritis	☐ Yes	☐ No
Epilepsy or Seizure Disorder	☐ Yes	☐ No
Multiple Sclerosis	☐ Yes	☐ No
Parkinson's disease	☐ Yes	☐ No
Other:		

Kidney and Bladder Health		
Kidney Disease *name:*	☐ Yes	☐ No
If yes, are you on dialysis?	☐ Yes	☐ No
Other:		

Other Significant Conditions:

CURRENT MEDICATIONS

☐ No prescription medications	☐ No over-the-counter medications, supplements, vitamins or probiotics

Medications, supplements, vitamins or probiotics:	Dose:	Frequency:	Indication:

ALLERGIES

Medication or Substance *(e.g. latex, food, etc.)*:	Type of Reaction:

ANESTHETIC HISTORY

Have you ever had general anesthesia?	☐ Yes	☐ No
If yes, please describe:		
Have you ever had regional anesthesia? *(e.g. nerve block, epidural, spinal, etc.)*	☐ Yes	☐ No
If yes, please describe:		
Have you had any reactions to anesthesia in the past?	☐ Yes	☐ No *If yes, check/describe below.*
☐ Malignant Hyperthermia ☐ Pseudocholinesterase ☐ Confusion after surgery		
☐ Other Reaction:		
Has a family member ever had a serious reaction to anesthesia?	☐ Yes	☐ No
If yes, please describe:		

ADDITIONAL SCREENING QUESTIONS

Do you bruise easily?	☐ Yes	☐ No	
Do you use home oxygen?	☐ Yes	☐ No	
Do you have loose teeth or dentures?	☐ Yes	☐ No	
Do you have any severe visual or hearing impairments?	☐ Yes	☐ No	
Do you drink alcohol?	☐ Yes	☐ No	If yes, number of drinks/week:
Do you smoke?	☐ Yes	☐ No	If yes, type + amount/week:
Do you use recreational drugs?	☐ Yes	☐ No	If yes, type + amount/week:
If female, are you currently pregnant?	☐ Yes	☐ No	☐ N/A

Patient Signature **Date** *(MM/DD/YY):*