Winchester District Memorial Hospital

PATIENTS PRE-OP QUESTIONNAIRE

The following questions have been designed for use by the Department of Anaesthesia. They are to be completed before the operation. Please answer each question carefully and return the completed sheet to the nurse as soon as possible.

ANSWER (X)

	YES	NO	Comments
1. Do you have any shortness of breath, chronic cough or asthma?			
2. Do you have an irregular heart beat, angina or chest pain?			
3. Do you have a cold, cough or fever at present?			
4. Have you ever had a reaction or complication to a local or general anaesthetic?			
5. Has a member of your family had a complication to a general anaesthetic? Example: Malignant Hyperthermia or MH			
6. Do you bleed excessively? (over 30 seconds to stop bleeding)			
7. Do you take a baby aspirin , ASA, Entrophen or any other over the counter aspirin product ?			
8. Do you have sleep apnea?			
9. Have you ever been told you have MRSA, VRE or C Diff?			
10. Do you have Hep C or any other blood borne disease?			
11 Do you have diabetes?			
12. Do you have a seizure disorder?			
13 Do you smoke?			
14. Have you taken a drug called cortisone or prednisone in the last year?			

15. List all previous surgeries?

_____

_____

_____

_____

_____
Date

_____
Signature of Patient

_____
Date

_____
Signature of Parent/Guardian

_____
Relationship

Current Medication List
Please list all prescription and natural medications you are presently on.

MEDICATION	*DOSE AND FREQUENCY*

Allergies:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

NURSE TO COMPLETE

SOURCE OF INFORMATION

_____Verified with PT _____PT/Family Recall _____Medication Record From Other Facility

_____Prescription or Medication List _____See Attached Photocopy

Completed By: _____
Date: _____