



3<sup>rd</sup> Floor, 715 Finlayson Street  
Victoria, BC, V8T 2T4

## Patient Questionnaire

*To be completed by you (patient) preferably 2 weeks prior to surgery. Fax to 250-595-1518.*

Patient Name	
PHN	
DOB	
Surgeon	
Family Dr.	
Date of Surgery	

1. Have you ever experienced:	YES	NO		YES	NO
Asthma.....	_____	_____	Muscle Disorders.....	_____	_____
Emphysema.....	_____	_____	Genetically Transmitted Illness .....	_____	_____
Chronic Bronchitis.....	_____	_____	Anemia.....	_____	_____
Chest Pain.....	_____	_____	Hepatitis.....	_____	_____
Heart Failure.....	_____	_____	HIV.....	_____	_____
High Blood pressure.....	_____	_____	Easy bruising.....	_____	_____
Persistent Irregular Heartbeat.....	_____	_____	Prolonged bleeding.....	_____	_____
Heart Attack.....	_____	_____	Post-surgical bleeding.....	_____	_____
Abnormal Heart Valves.....	_____	_____	Diabetes.....	_____	_____
Stroke.....	_____	_____	Loose teeth.....	_____	_____

2. Have you or a family member ever had a serious complication from general anesthesia?..      yes      no

3. Do you experience nausea with anesthetics? .....      yes      no

4. Is your activity limited by illness? .....      yes      no

5. Is there any significant chance you may be pregnant? .....      yes      no

6. What surgeries have you had in the past?

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7. What pain killers work well for you?

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8. Are you aware of any pain killers that do not work well, or cause you unpleasant side effects? If so, please list.      yes      no

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9. Are you taking any medications? Please list -      yes      no

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10. Please state your allergies      None known

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