DR. GRANT LU MD, CCFP, FRCPC (Anesthesia) **Form B**

PRE-ANESTHETIC HEALTH QUESTIONNAIRE

PATIENT'S NAME:		HEALTH CARD #:	
GUARDIAN (IF MINOR):		DATE OF EXPIRY:	DD / MM / YYYY
ADDRESS:		DATE OF BIRTH:	DD / MM / YYYY
		HEIGHT:	
		WEIGHT:	
PHONE #:		DIAGNOSIS:	
SURGEON:		PROCEDURE:	
FAMILY DOCTOR:		SCHEDULED O.R. DATE:	DD / MM / YYYY

DO YOU HAVE OR EVER HAD	Yes	No	DO YOU HAVE OR EVER HAD	Yes	No	ARE YOU NOW TAKING, OR HAVE YOU EVER TAKEN, ANY OF THE FOLLOWING?	Yes	No
Diabetes	❑	❑	Chronic Cough	❑	❑		❑	❑
Heart Attack	❑	❑	Bronchitis or Emphysema	❑	❑		❑	❑
Angina or Chest Pain	❑	❑	Asthma/Wheezing	❑	❑	Chemotherapy	❑	❑
Skipped Heart Beats/Abnormal rhythm	❑	❑	Sputum	❑	❑	Cortisone	❑	❑
Pacemaker	❑	❑	Recent Fever, Chills, Flu or Cold	❑	❑	Aspirin (within the last 10 days)	❑	❑
High Blood Pressure	❑	❑	Pneumonia or TB	❑	❑	Blood Thinners	❑	❑
Rheumatic Fever/Heart Murmur	❑	❑	Epilepsy/ Seizure disorder	❑	❑	Water Pills	❑	❑
Swelling of Ankles	❑	❑	Stroke	❑	❑	Digoxin / Heart Pills	❑	❑
Heart Valvular Disease/Abnormality	❑	❑	Numbness or Weak Limbs	❑	❑	Are you a smoker?	❑	❑
Blood Transfusions or Anemia	❑	❑	Fainting Spells	❑	❑	# per day		
Reactions to Blood	❑	❑	Kidney Trouble	❑	❑	Alcohol Use	❑	❑
Bleeding Problems	❑	❑	Jaundice, Hepatitis or Cirrhosis	❑	❑	Amount		
H.I.V. Exposure	❑	❑	Hiatus Hernia	❑	❑	How often		
Shortness of Breath	❑	❑	Physical Disability	❑	❑	Dentures	❑	❑
Congenital Heart Disease/Abnormality	❑	❑	Temporomandibular Joint Disorder	❑	❑	Antibiotics before dental treatment	❑	❑
Autism	❑	❑						
Developmental Disorder	❑	❑	Mental/Psychiatric Problems	❑	❑	Herbal/Nonprescription Remedies	❑	❑
			Sleep apnea	❑	❑	CPAP/BIPAP	❑	❑

DO YOU HAVE:	Loose Teeth	Bridge	Crowns/Caps	Veneers	Other dental/oral treatment
LIST:					

MEDICAL PROBLEMS NOT LISTED ABOVE OR SEEING MD OR SPECIALIST FOR CURRENT OR PAST CONDITION::

LIST PREVIOUS SURGERIES:
HOSPITAL NAME AND DATE

MEDICATIONS

ARE YOU TAKING ANY:	YES	NO
Prescription Drugs	❑	❑
Street Drugs	❑	❑
Over the Counter – Vitamins, etc.	❑	❑

HAVE YOU (OR ANY RELATIVE) HAD A PROBLEM WITH ANESTHETICS? (HIGH FEVER, MALIGNANT HYPERTHERMIA) ❑ Yes ❑ No Specify:
RELATIONSHIP TO PATIENT:

CURRENT MEDICATIONS	DOSAGE

PLEASE BRING ALL MEDICATIONS YOU ARE TAKING TO THE DENTAL OFFICE

ALLERGIES

❑ Yes ❑ No If "Yes", please list below and describe reaction.

MEDICATIONS ALLERGIES	FOOD ALLERGIES	OTHER ALLERGIES		
		Adhesive (e.g. tape)	❑ Yes	❑ No
		Latex (e.g. rubber gloves)	❑ Yes	❑ No

EMERGENCY CONTACT – DAY OF SURGERY NAME | RELATIONSHIP:

PHONE #