Kensington HEALTH

340 COLLEGE ST, SUITE 600, TORONTO, ONTARIO, M5T 3A9 | PHONE: 416-928-9511 | FAX: 416-928-9513 | www.kensingtonhealth.org/screening-clinic

Patient Sticker:

KENSINGTON SCREENING CLINIC: DEPARTMENT OF ANESTHESIA PRE-OPERATIVE QUESTIONNAIRE

to be filled out by care team

ANESTHETIST: ____________________ SIGNATURE: ____________________ KSC CRITERIA MET: ☐ Y ☐ N

(PLEASE PRINT NAME)

ANY ADDITIONAL INFORMATION: ____

ENDOSCOPIST: ____________________ PROCEDURE: ☐ EGD ☐ COLONOSCOPY ☐ FLEX SIG

Please complete all of the information (every field) on this two-page form. This form **MUST** be faxed to Kensington Screening clinic at 416-928-9513 or emailed to endoscopy@kensingtonhealth.org **NO LATER THAN 5 DAYS PRIOR TO THE DATE OF YOUR PROCEDURE OR IT MAY BE CANCELLED. AN INCOMPLETE FORM MAY RESULT IN CANCELLATION OF YOUR PROCEDURE.**

PATIENT NAME: ____________________ ____________________ WEIGHT: ______ HEIGHT: ______

(LAST NAME) (FIRST NAME)

PHONE #: ____________________ DATE OF BIRTH: ______________ DATE OF PROCEDURE: ______________

(YY/MM/DD) (YY/MM/DD)

Please list all the medications that you are currently taking including prescription, inhalers, herbal or non-prescription drugs (include the dose and how often you take the medicine):

Please list any allergies (eg. drugs, latex, etc):

MEDICAL HISTORY: Please check the box if you have or have ever had any of the following

- ☐ RECENT COLD OR FLU
- ☐ HEART ATTACK
- ☐ CHEST PAIN (ANGINA)
- ☐ IRREGULAR HEART BEAT
- ☐ HEART MURMUR
- ☐ HEART VALVE PROBLEMS
- ☐ ANGIOPLASTY
- ☐ PACEMAKER
- ☐ RHEUMATIC FEVER
- ☐ HIGH BLOOD PRESSURE
- ☐ SHORTNESS OF BREATH
- ☐ COUGH WITH SPUTUM
- ☐ ASTHMA
- ☐ TUBERCULOSIS
- ☐ CHRONIC INFECTION:
- ☐ HEPATITIS
- ☐ HIV
- ☐ DIABETES
- ☐ THYROID PROBLEMS
- ☐ KIDNEY PROBLEMS
- ☐ DIALYSIS
- ☐ LIVER PROBLEMS
- ☐ JAUNDICE
- ☐ ABNORMAL BLEEDING
- ☐ ANEMIA
- ☐ STROKE OR TIA (MINISTROKE)
- ☐ BLOOD CLOT (LUNG OR ELSEWHERE)
- ☐ EASY BRUISING
- ☐ REACTION TO BLOOD TRANSFUSION
- ☐ PHYSICAL DISABILITY
- ☐ SLEEP APNEA
- ☐ NUMBNESS OR WEAKNESS ANYWHERE
- ☐ FAINTING OR DIZZY SPELLS
- ☐ EPILEPSY OR SEIZURES
- ☐ PSYCHIATRIC PROBLEMS
- ☐ HEARTBURN OR STOMACH PROBLEMS
- ☐ NECK PROBLEMS
- ☐ ARTHRITIS OR BACK PROBLEMS
- ☐ JAW PROBLEMS
- ☐ LOOSE TEETH, CAPS, DENTURES, ETC

Attach medical records/notes from your specialist pertaining to heart or other concerning condition(s).

Please provide details for any condition checked:

____

____

____

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MEDICAL HISTORY: Please check the box if you have or have ever had any of the following

DATE (YY/MM/DD)	SURGERY	GENERAL ANAESTHETIC	LOCAL ANAESTHETIC	UNKNOWN
______	______	☐	☐	☐
______	______	☐	☐	☐
______	______	☐	☐	☐
______	______	☐	☐	☐
______	______	☐	☐	☐

Have you or any blood relative had a problem with anesthetic? If yes, please explain: ☐ Y ☐ N

______

______

Have you or a blood relative had any of the following:

☐ MALIGNANT HYPERTHERMIA ☐ PORPHYRIA ☐ CHOLINESTERASE DEFICIENCY ☐ SICKLE CELL

Do you smoke? ☐ Y ☐ N If yes, how many per day? ______

Do you drink alcohol? ☐ Y ☐ N If yes, how much per day? ______

Do you use recreational drugs? ☐ Y ☐ N If yes, what? ______

Are you pregnant? ☐ Y ☐ N

How far can you walk before you become tired? ______

How many flights of stairs can you climb without stopping? ______

Has your Family Doctor referred you for any condition to a Medical Specialist? ☐ Y ☐ N

IF YES, WHO?	AND FOR WHAT?
______	______
______	______
______	______

Is there any other significant illness not mentioned or other information you would like to provide to your Anesthesiologist?

______

Please be aware that damage can occur to teeth during anesthetic, especially if you have loose teeth or caps. Please discuss any concerns with your anesthesiologist. It is extremely important that you follow the instructions provided to you about not eating and drinking before your procedure.

I have answered the questions as accurately and truthfully as possible.

PATIENT SIGNATURE: ______ DATE: ______
(YY/MM/DD)