New Brunswick Pre-Operative Questionnaire

Patient Name:	
Medicare Number:	
Address:	
Date of Birth (yyyy/mm/dd):	
Height:	Weight:
Family Doctor:	
Surgeon:	
Email Address:	
Daytime/work phone:	
Cellphone:	
Home phone:	

Form completed by: Patient ☐ Other ☐			
If other, Name:	Relationship:	Phone number:	
Date Completed (yyyy/mm/dd):		Do you have a drive home? Yes ☐ No ☐	
1. Do you smoke? Yes ☐ No ☐	How many cigarettes a day?	How many years have you smoked?	
a. Have you ever smoked? Yes ☐ No ☐		When did you quit?	
b. Do you use tobacco in any other form? Yes ☐ No ☐		Do you vape? Yes ☐ No ☐	
2. Do you drink alcohol, wine, or beer? Yes ☐ No ☐	How much?	How often?	
3. Do you use recreational drugs? Yes ☐ No ☐	Type:	How often?	
4. Are you taking aspirin or an anticoagulant (Coumadin, Plavix, Pradaxa, Xarelto, Eliquis)? If yes, please circle ☐ No ☐			
5. Have you taken prednisone, cortisone, or steroids in the past 12 months? (not including inhalers and intra-articular or orthopedic injections) Yes ☐ No ☐			
6. When was the last time you had general anesthetic?		What hospital?	
7. Is it possible that you are pregnant? Yes ☐ No ☐	Last menstrual period?		

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING? (Circle all that apply)	Yes	No
8. a) Restrictions or difficulty with neck movement or opening your mouth? b) Have you been told you are difficult to intubate?	☐ ☐	☐ ☐
9. Capped, loose or false teeth, dentures, partial plates?	☐	☐
10. Asthma, chronic bronchitis, COPD, TB?	☐	☐
11. Are you on Home Oxygen?	☐	☐
12. Chronic or troublesome cough?	☐	☐
13. a) Shortness of breath at rest or when lying flat? b) Can you walk up two flights of stairs without having to stop and catch your breath?	☐ ☐	☐ ☐
14. a) Sleep apnea (stop breathing in your sleep)? b) Do you use a CPAP or BIPAP machine?	☐ ☐	☐ ☐
15. a) Any unusual or serious reaction to any kind of anesthetic? b) Any blood relatives had serious reactions to anesthetic? c) Suffer from malignant hyperthermia or pseudocholinesterase deficiency? d) Nausea or vomiting after an anesthetic?	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
16. Heart problems such as heart murmur, valve replacements, pacemakers, defibrillator, or serious rhythm disorder?	☐	☐
17. Angina, heart attack, cardiac stent, bypass or open-heart surgery? Chest pain?	☐	☐
18. High blood pressure?	☐	☐
19. Blackouts or fainting spells in the last year?	☐	☐

20.	Stroke, mini-stroke, severe muscle weakness or paralysis of any part of your body?			Yes ☐	No ☐
21.	Epilepsy, seizure, or a significant neurological disorder?	Yes ☐	No ☐	Date of last seizure:	
22.	a) Kidney disease?	Yes ☐	No ☐	b) Dialysis? Yes ☐	No ☐
23.	Diagnosed with rheumatoid arthritis (not osteoarthritis)?			Yes ☐	No ☐
24.	a) Current low blood count (anemia) or other blood disorders?			Yes ☐	No ☐
	b) Had a blood or platelet transfusion?			Yes ☐	No ☐
	c) Blood clots in the legs (DVT) or lungs (pulmonary embolism)?			Yes ☐	No ☐
25.	Diabetes?	Yes ☐	No ☐	Type I ☐	Type II ☐
26.	Chronic Pain?	Yes ☐	No ☐		
27.	Thyroid problems?	Yes ☐	No ☐		
28.	Significant problems with stomach acid, heartburn, or hiatus hernia?			Yes ☐	No ☐
29.	Hepatitis, HIV / AIDS, liver problems, pancreatitis, or splenectomy?			Yes ☐	No ☐
30.	Have you had or been exposed to MRSA, VRE or ESBL?			Yes ☐	No ☐

List any major illnesses (physical, mental)

List any operations you have had including where and when the surgeries were performed

Year	Reason	Hospital

List any allergies

Allergy	Reaction	Allergy	Reaction

Do you take any medications? Yes ☐ if yes, please list below No ☐ Pharmacy name:
List and bring all medications, including your prescription drugs, herbal, vitamins, inhalers, and over-the-counter drugs.

Name of Drug	Dose(mg)	Frequency	Reason

HOSPITAL USE ONLY below this line:

Preliminary Screening reviewed by:	Date:
Nurse Consult: By phone ☐ Clinic visit ☐	Anesthesia consult required: Yes ☐ No ☐
Nurse Consult completed by: Name Initials	Date : (mm/dd/yyyy)
Preliminary Screening reviewed by:	Date:
Nurse Consult: By phone ☐ Clinic visit ☐	Anesthesia consult required: Yes ☐ No ☐
Nurse Consult completed by: Name Initials	Date : (mm/dd/yyyy)