kensington SCREENING CLINIC

DEPARTMENT OF ANESTHESIA PRE-OPERATIVE QUESTIONNAIRE REVIEW
(OFFICE USE ONLY)
Anesthetist: _____ **Signature**_____ **KSC Criteria met Yes** _____ **No** _____
(Please print name)

Require additional information: Specify _____

Please complete all of the information 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 6 DAYS PRIOR TO THE DATE OF YOUR PROCEDURE OR IT MAY BE CANCELLED.

ENDOSCOPIST: _____ **SCHEDULED PROCEDURE:** ☐ **EGD** ☐ **Colonoscopy** ☐ **EGD/Colonoscopy** ☐ **Flex Sig**
(name of doctor)

Patient Name: _____ _____ **Patient Phone#** _____
(PRINT Last Name) (PRINT First Name)

Date of Birth:_____ **Date of Procedure:** ___/___/___ **Weight**_____**Lbs/KG** ☐☐ **Height**_____**Ft/M** ☐☐
(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 drug allergies (or latex):

_____

_____

MEDICAL HISTORY:
Please check the box if you have or have ever had any of the following:
Please attach medical records/notes from your specialist pertaining to heart or other concerning condition(s)

- ☐ 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

Please be aware that despite care, damage can occur to teeth during an anesthetic. Please discuss any concerns with your Anesthesiologist.

Please provide details for any condition checked

_____

_____

_____

SURGICAL HISTORY:

Please list below all surgical procedures you have had.

Date (MM-DD-YYYY)	Surgery	General Anaesthetic	Local Anaesthetic	Unknown
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

Have you or any blood relative had a problem with anesthetic? ☐ **yes** ☐ **no**

If yes, please explain:

_____

_____

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

☐ **Malignant hyperthermia** ☐ **Porphyria** ☐ **Cholinesterase deficiency** ☐ **Sickle cell**

GENERAL HEALTH:

Do you smoke? If yes, how many per day? _____ ☐ **no**

Do you drink alcohol? If yes, how much per day? _____ ☐ **no**

Do you use recreational drugs? If yes, what? _____ ☐ **no**

Are you pregnant? ☐ **yes** ☐ **no**

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? ☐ **yes** ☐ **no**

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?

_____

_____

_____

It is extremely important that you follow the instructions provided to you about not eating and drinking before your procedure. Please review your instructions carefully.

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

I, the applicant for this form, warrant the truthfulness of the information provided in this application.

Patient's Signature_____ **Date** _____

(YY/MM/DD)

Submit via email