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ANAESTHESIA for DENTISTRY

(416) 839-4777

Pre-Anaesthesia Questionnaire (Adult)

Date of Birth: _____

Name _____ Date _____

	Yes	No	Not sure
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1. Do you have any health problems or concerns presently? Yes No Not sure

2. Has there been ANY change in your general health in the past year? Yes No Not sure
When did you last have a complete physical exam? (month)_____ (year) ____
How often do you see your family doctor or specialist? Every_____

3. Have you ever been in hospital for treatment? _____ Yes No Not sure
When, where and why? _____

4. Have you ever had general anaesthesia or surgery? _____ Yes No Not sure
When, where and why? _____
Were there any problems with the anaesthesia? _____

5. Have you or any of your family relatives had problems with anaesthesia? Yes No Not sure
Please explain.
Were any tests done?

6. Do you have a drug allergy? Yes No Not sure
What drug?
What year?
What happened? (Circle) rash breathing problems/wheezing swelling

7. Do you have any other allergies (e.g. latex)? _____ Yes No Not sure

8. Do you take ANY medications (including puffers and birth control pills)? Yes No Not sure
Please list or bring a list of all of your medications or bring them to the office:
Name _____ Dose _____

9. Do you use or take ANY non-prescription remedies (including herbal remedies)? Yes No Not sure
Name _____

10. Have you taken a cortisone (steroid) type drug orally in the past year? Yes No Not sure
When? _____ How long were you taking it for? _____

11. Do you or any of your relatives have a bleeding problem? Yes No Not sure

12. Do you have or have had any difficulty breathing through your nose? Yes No Not sure

13. Do you have any nose bleeds? If so how many per week? _____ Yes No Not sure

14. Do you have or have had any difficulty breathing while sleeping at home? Yes No Not sure

15. Can you walk up 2 flights of stairs or 2 city blocks quickly without resting? Yes No Not sure