MARKHAM STOUFFVILLE HOSPITAL

☐ Markham Site ☐ Uxbridge Site

ANAESTHESIA PATIENT QUESTIONNAIRE

Date

Name:

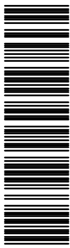
Date of Birth:

Health card #:

1. List all your previous Surgeries ☐ I have had no Surgeries

Procedure	Hospital	Year

Question	Yes	No	Don't Know
2. Have you or any family members (including aunts, uncles & cousins) had an adverse reaction to anaesthetic drugs? e.g. malignant hyperthermia	☐ Yes	☐ No	
3. Have you ever had heart problems? (if yes, please check which one) Heart Attack, Angina, Rheumatic Fever, Heart Murmur, Rhythm problems, Other:	☐ Yes	☐ No	
4. Have you ever had high blood pressure?	☐ Yes	☐ No	
5. Have you had chest or breathing problems? (if yes, please check which one) Asthma Emphysema, Bronchitis, Tuberculosis, Pneumonia, Sleep Apnea, Other:	☐ Yes	☐ No	
6. Have you had an injury or do you have a condition affecting your neck or jaw?	☐ Yes	☐ No	
7. Have you had Hepatitis A, B or C? (if yes, please specify):	☐ Yes	☐ No	
8. Have you had or do you have diabetes? (if yes, please check) Diet Controlled Oral Medication Insulin Dependent	☐ Yes	☐ No	
9. Do you have or have you had kidney problems, stroke, epilepsy?	☐ Yes	☐ No	
10. Have you had a blood transfusion in the last 3 months?	☐ Yes	☐ No	
11. Do you have bleeding problems?	☐ Yes	☐ No	
12. Do you have false teeth, caps, crowns, loose teeth, contact lenses, hearing aid? (if yes, please check off which ones)	☐ Yes	☐ No	
13. Do you smoke? (if yes, amount per week)	☐ Yes	☐ No	
14. Do you drink alcohol? (if yes, amount per week)	☐ Yes	☐ No	
15. Do you have a history of complications during pregnancy? e.g. toxemia ☐ N/A	☐ Yes	☐ No	
16. Have you taken steriods in the last 6 months? (not including Cortisone Injections)	☐ Yes	☐ No	
17. Are you allergic to anything (medications, latex, food, environmental, other)? (if yes, please list)	☐ Yes	☐ No	



18. List current regular medications you are taking, including over-the-counter drugs.

19. List serious illnesses you have had in your life and the approximate year.

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Markham, Ontario L3P 7P3

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OBSTETRICAL CONSENT TO TREATMENT

Name of Patient: ____

1. I consent to those treatments/procedures/operations deemed necessary which reflect responsible management of my pregnancy/labour/birth/postpartum care. The consent includes the routine and emergency care of my newborn baby/babies.

2. I further agree that the practitioner below may assign other surgeons, physicians, midwives and hospital staff to perform all or part of the investigation, treatment or operative procedures. I also agree that they shall have the same discretion in my investigation and treatment.

3. I understand that Markham Stouffville Hospital has teaching commitments and various healthcare personnel may be involved in my care during the Hospital stay.

4. If it is determined to be medically advisable during the course of my treatments/procedures/ operations, I give my consent to the administration of anaesthetics/pain medication including, but not limited to local, regional (e.g., epidural) or general anaesthetic.

5. I request and expect that in a situation where additional procedures may be deemed necessary, (e.g. a Caesarean section, forceps birth, vacuum birth) every opportunity will be taken to explain the circumstances to me and my support person insofar as time and safety permits.

6. In compliance with provinical legislation, I acknowledge that the hospital may utilize tissue specimens removed during my procedures for research and/or teaching purposes.

7. The possibility of the administration of blood or blood products including Rho(D)Immune Globulin (RhIG) has been fully discussed with me, and a consent or refusal form for blood or blood products has been completed as per this discussion.

8. I confirm that I have had ample opportunity to raise questions concerning the expected benefits and material side effects of treatment/procedures/operation involved in the management of my pregnancy/labour/birth/postpartum care and the routine care of my newborn baby/babies. I confirm that I understand, accept and am satisfied with the explanations provided.

____
Signature of Patient
(or Substitute Decision Maker, if applicable)

____
Name of Substitute Decision Maker, if applicable

____
Signature of Physician/Midwife

____
Date

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CONSENT FOR TRANSFUSION OF BLOOD AND/OR BLOOD PRODUCTS

1. I have been informed that during my treatment, it may be necessary to receive a transfusion of blood and/or blood products. I understand what a transfusion is and the procedure that will be used.
2. I have been given written educational material about the risks and benefits of blood products and have had the opportunity to discuss any questions and concerns with my health care provider.
3. I understand that the Canadian Blood Services (CBS) has taken the accepted precautions in selecting blood donors and in collecting, testing and storing blood and blood products for transfusion. I understand that Markham Stouffville Hospital and its staff have taken the accepted precautions in storing and preparing the product(s) for transfusion.
4. I have been told about the risks of receiving a transfusion from volunteer donors. I understand that no absolute guarantees can be or have been given to me concerning the potential risks associated with the transfusion of blood and/or blood products. I understand that risks exist even though the bood has been tested and may even be my own.
5. In some cases, my own blood (autologous) may be used for transfusion. I have been made aware that there are risks even with donating or receiving my own blood and I have discussed this with my doctor. I have been told that even if my own blood is used, it may be necessary to give me additional blood or blood products donated by others.

The treatment and transfusion procedure has been fully explained to me. By signing below I accept that I understand the associated risks and benefits and that I have had an opportunity to ask and have my questions answered.

______________________ Signature of Patient	OR	______________________ Signature of Substitute Decision Maker
______________________ PRINT Patient Name		______________________ PRINT Substitute Decision Maker Name/Relationship
__________ Date		__________ Date

Physician Statement:

I have explained the nature of the treatment, its associated risks, benefits, possible alternatives, as well as the likely consequences of not having treatment. I have provided the appropriate written information and have answered any request for additional information by the patient or Substitute Decision Maker.

Physician/Surgeon Signature ______________________ Date __________

PRINT Physician/Surgeon Name ______________________