

ANESTHESIA QUESTIONNAIRE

LAST FOOD	LAST FLUID	BP	PULSE	RESP.	TEMP	O ₂ SAT
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I. DRUGS AND MEDICATIONS:

List all medications you take, and the dosage, (including herbal supplements, vitamins, over-the-counter drugs, and recreational drug use if any): _____

Do you have any **MEDICATION ALLERGIES?** Yes No

If "YES" please list: _____

Do you have any **FOOD ALLERGIES?** Yes No

If "YES" please list: _____

Do you have **SLEEP APNEA?** Yes No

If "YES," call 472-3824 IMMEDIATELY.

Are you allergic to **LATEX** or **RUBBER PRODUCTS?** Yes No

List any other hospitalizations with reasons and approximate dates and any chronic illness(es) or condition(s): _____

Primary Care Physician: _____ Phone: _____

Specialty Physician: _____ Phone: _____

II. SURGERIES:

List all previous operations, year, and type of anesthesia. (gen, local, spinal) _____

III. HEIGHT: _____ **WEIGHT:** _____

IV. HAVE YOU HAD:

PLEASE CIRCLE (IF YES, PLEASE EXPLAIN)

- | | | | |
|---|-----|----|-------|
| 1. High Blood Pressure | Yes | No | _____ |
| 2. Heart trouble or Heart Attack | Yes | No | _____ |
| a) Chest pain or Angina | Yes | No | _____ |
| b) Irregular Heart Beat | Yes | No | _____ |
| c) Congestive Heart Failure | Yes | No | _____ |
| d) Abnormal electrocardiogram | Yes | No | _____ |
| 3. Gastric Esophageal Reflux, Hiatal Hernia, Ulcers: | Yes | No | _____ |
| 4. A recent cold, cough or sore throat | Yes | No | _____ |
| 5. Asthma, Emphysema, bronchitis or breathing problem | Yes | No | _____ |
| 6. Abnormal chest x-ray | Yes | No | _____ |
| 7. Diabetes | Yes | No | _____ |
| 8. Yellow jaundice or hepatitis | Yes | No | _____ |
| 9. Kidney Disease | Yes | No | _____ |
| 10. Abnormal bleeding problems | Yes | No | _____ |
| 11. Stroke, numbness or weakness | Yes | No | _____ |
| 12. Epilepsy or convulsive seizures | Yes | No | _____ |
| 13. Broken bones of back, neck or face | Yes | No | _____ |
| 14. Back trouble | Yes | No | _____ |
| 15. Unusual muscle problems or diseases | Yes | No | _____ |
| 16. Unexplained fevers or heatstrokes | Yes | No | _____ |
| 17. Bad reactions to anesthetics | Yes | No | _____ |
| 18. Any relative with bad reaction to anesthetics | Yes | No | _____ |
| 19. Psychological or emotional problems | Yes | No | _____ |
| 20. Any problems with motion sickness | Yes | No | _____ |

V. DO YOU:

- | | | | |
|--|-----|----|-------|
| 1. Wear Dentures | Yes | No | _____ |
| 2. Have caps on teeth | Yes | No | _____ |
| 3. Drink alcohol (How much per day) | Yes | No | _____ |
| 4. Smoke (How much per day) | Yes | No | _____ |
| 5. Exercise or have strenuous activity | Yes | No | _____ |
| 6. Have physical limitations | Yes | No | _____ |

VI. Female (if applicable) are you pregnant Yes No _____

VII. Are you aware there is a risk with **EVERY** Anesthetic given Yes No _____

VIII. Do you have questions or concerns you would like to discuss with your Anesthesiologist? _____

Phone number you can be reached at the evening before surgery: () - _____

Signed by Patient _____ Date _____

Questionnaire and Pre-Op teaching done by _____ Date _____

Print Patient Name _____