

PRE-ANESTHESIA QUESTIONNAIRE

Please completely answer **ALL** the following questions. Thank you!

Name: _____

Age _____ Sex: M F Height _____ Weight _____ Are you pregnant? YES NO

Home/Cell Phone #: _____ Work Phone #: _____ E-mail Address: _____

Adult driving you home after your procedure? _____ Their Cell #: _____

Do you smoke? YES NO How much each day? _____ Are you Diabetic? YES NO

Have you or any family member had an unusual reaction to anesthesia? YES NO Describe: _____

_____ Are you allergic to LATEX? YES NO

Medication Allergies: _____

Regular Medications: _____

Have you been ill or had a fever lately YES NO Do you have any prosthetics? YES NO

Are you taking addictive drugs? YES NO Do you drink alcohol daily? YES NO

Do you have, or have you had, any of the following?

| | Yes | No | When? | | Yes | No | When? |
|--|--------------------------|--------------------------|-------|-----------------------------|--------------------------|--------------------------|-------|
| Lung Trouble | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Bronchitis / Chronic Cough | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Bleeding Problem | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Shortness of Breath | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Pneumonia | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Liver Problem | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Gall Bladder Problem | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Tuberculosis (TB) | <input type="checkbox"/> | <input type="checkbox"/> | _____ | GI Bleeding | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Sleep Apnea CPAP? | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Seizures / Seizure Disorder | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Stroke | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Paralysis | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Head, Neck or Spine Injury | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Heart Murmurs | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Kidney Trouble | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Chest Pain | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Thyroid Disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Heart Valve Problem | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Gastric Reflux (GERD) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Palpitations / Irregular or Fast Beats | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Frequent indigestion | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Pacemaker? Rate _____ | | | | Hiatal Hernia | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Back / Disc Problems | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Phlebitis | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Sciatica | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Any illness or disease not listed? _____

Please provide any information you feel would be helpful to us in caring for you: _____

Previous Surgeries:

- Appendectomy Hernia Gallbladder Breast/Biopsy Glaucoma
 Hysterectomy Cataracts Sinus / Nasal Tubal Ligation Tonsils / Adenoids
 Orthopaedic Other _____

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PATIENT IDENTIFICATION