PRE-ANESTHESIA QUESTIONNAIRE

Please answer all questions completely.

Patient Name:_______________ DOB:__________ Height:________ Weight:__________

What is the best day time # (_____)-____________________ May we leave a message at this # ☐ Yes ☐ No

Primary Care Doc:____________________ Last Seen________ Cardiologist:________________ Last Seen__________

Surgery date:__________ Surgeon:______________________ Surgery Scheduled:______________________

☐ Yes ☐ No Do you take blood thinners such as Coumadin, Warfarin, or any others________________

☐ Yes ☐ No Have you been instructed by a Doctor to take Aspirin, if yes, doctor's name________________

☐ Yes ☐ No Do you or a family member have blood clotting problems,if yes, explain:________________

List all past surgeries, including dates performed:____

____

____

PATIENT MEDICAL HISTORY:

- ☐ Yes ☐ No Diabetes
- ☐ Yes ☐ No Heart Problems (see back)
- ☐ Yes ☐ No Kidney Disease
- ☐ Yes ☐ No Gastric Ulcers
- ☐ Yes ☐ No Urinary Problems
- ☐ Yes ☐ No GERD/Acid Reflux
- ☐ Yes ☐ No Hiatal Hernia
- ☐ Yes ☐ No Thyroid Disease
- ☐ Yes ☐ No TB
- ☐ Yes ☐ No HIV/AIDS
- ☐ Yes ☐ No Hepatitis - if **yes,** type ☐ A ☐ B ☐ C
- ☐ Yes ☐ No MRSA (active)

PATIENT MEDICAL HISTORY:

- ☐ **Yes** ☐ **No** **Could you be pregnant, if so how many weeks?**__________
- ☐ Yes ☐ No Cancer - If yes,what kind?____________________
- ☐ Yes ☐ No Diagnosed with sleep apnea
- ☐ Yes ☐ No Do you use a C-Pap machine
- ☐ Yes ☐ No Is your shirt collar larger than 17" for men? 16" for women?
- ☐ I do not know
- ☐ Yes ☐ No Do you snore loudly
- ☐ Yes ☐ No Are you often tired /fatigued during the day
- ☐ Yes ☐ No Has anyone ever observed you stop breathing in your sleep
- ☐ Yes ☐ No Do you have: (circle all that apply)
  - Loose teeth False teeth
  - Capped teeth Dentures Bridges

ALLERGIES:

____

____

NON-MEDICATION ALLERGIES:

☐ Yes ☐ No Latex allergy, if yes, explain reaction:________________________________

☐ Yes ☐ No Have you had problems with: Iodine____ Adhesives____

☐ Yes ☐ No Have you had any problems with anesthesia, if yes, explain________________________

☐ Yes ☐ No Family History of Malignant Hyperthermia, if yes, explain________________________

RESPIRATORY: check yes or no - (If marked yes, explain)

☐ Yes ☐ No Shortness of Breath at rest________________________________

☐ Yes ☐ No Chronic Dry Cough or Productive Cough________________________________

☐ Yes ☐ No Asthma/Wheezing? Do you use inhalers? ☐ Yes ☐ No - If yes, please bring with you on your day of surgery

NEUROLOGIC/MENTAL HEALTH: check yes or no - (If marked yes, explain)

☐ Yes ☐ No Headaches/Migraines________________________________

☐ Yes ☐ No Seizures/Convulsions, If yes, when was the last one________________________

CARDIOVASCULAR: check yes or no· (If marked yes, explain)

☐ Yes ☐ No Stroke or TIA, if so, when____________________

☐ Yes ☐ No High Blood Pressure____________________

☐ Yes ☐ No Arrhythmias____________________

☐ Yes ☐ No Chest pain____________________

☐ Yes ☐ No **Pacemaker/Defibrillator:** Make____________Model____________Last checked____________

MUSCULOSKELETAL: check yes or no (If marked yes, explain)

☐ Yes ☐ No Any back/neck problems or neck fusions, if yes, what vertebrae____________________

☐ Yes ☐ No Any muscle weakness, numbness, or paralysis anywhere, if yes, explain

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IMPLANTS/PROSTHESIS: check yes or no (If marked yes, explain)

☐ Yes ☐ No Artificial Joint, if so, where:____________________

☐ Yes ☐ No Artificial Heart Valve

☐ Yes ☐ No Have you been told to take "antibiotics" prior to having surgery or dental procedures because of an artificial heart valve, artificial joint, if yes, what is prescribed____________________

HABITS:

☐ Yes ☐ No Recreational drug use, including cannabis, if so what form/kind____________________

☐ Yes ☐ No Drink alcohol, if so, amount per day/wk____________________

☐ Yes ☐ No Smoke? How long? ____________ # packs per day______Cigarettes______Cigars______Pipe______Chew______

☐ Yes ☐ No Quit? How long ago? ________________

Please list all current medications, the dose you take, and how frequently you take it. (eg. daily, twice a day, etc.)

Medication	Dose	Frequency

List any other previous or current medical conditions not mentioned above:

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Patient Name ____________________ Signature ____________________ Date ____________________

Parent/Guardian Name ____________________ Signature ____________________ Relationship to patient Date ____________________