



PRE-ANESTHESIA QUESTIONNAIRE

Patient Name: _____ Date: _____

Age: _____ DOB: _____ Procedure: _____

I AGREE TO HAVE NOTHING BY MOUTH AFTER MIDNIGHT THE NIGHT BEFORE MY SURGERY UNLESS INSTRUCTED TO DO SO.

- 1. ()Yes ()No Is this your first anesthetic?
- 2. ()Yes ()No Have you had any problems with anesthesia? Specify: _____
- 3. ()Yes ()No Have members of your family had problems with anesthesia? Specify: _____
- 4. ()Yes ()No If female, are you having your period?
- 5. ()Yes ()No Wearing a tampon?
- 6. ()Yes ()No Are you or could you be pregnant?

DO YOU OR HAVE YOU HAD:

- 1. ()Yes ()No Heart disease (including heart murmur, pacemaker, bypass surgery, mitral valve prolapsed, irregular heartbeat?)
- 2. ()Yes ()No High blood pressure?
- 3. ()Yes ()No Lung Disease?
- 4. ()Yes ()No Asthma?
- 5. ()Yes ()No Kidney disease? Specify: _____
- 6. ()Yes ()No Liver disease/Hepatitis?
- 7. ()Yes ()No Jaundice (yellow color of skin/eyes)? Specify: _____
- 8. ()Yes ()No Diabetes?
- 9. ()Yes ()No Epilepsy/Seizures? Neurological problems?
- 10. ()Yes ()No Thyroid or goiter problems?
- 11. ()Yes ()No Bowel/Colon disease or problems? Specify: _____
- 12. ()Yes ()No Chest pain?
- 13. ()Yes ()No Shortness of breath?
- 14. ()Yes ()No Chronic cough?
- 15. ()Yes ()No Back trouble? Specify: _____
- 16. ()Yes ()No Neck trouble? Specify: _____
- 17. ()Yes ()No Muscle weakness?
- 18. ()Yes ()No Past/Present possible carrier of contagious disease? Specify: _____
- 19. ()Yes ()No Bleeding or clotting abnormalities? Specify: _____
- 20. ()Yes ()No Nose surgery, broken bones in your face or back? Specify: _____
- 21. ()Yes ()No Blood transfusions?
- 22. ()Yes ()No An abnormal chest x-ray?
- 23. ()Yes ()No An abnormal EKG?
- 24. ()Yes ()No Any exposure to communicable disease in the past 3 weeks? Explain: _____
- 25. ()Yes ()No Any allergies? Specify: _____
- 26. ()Yes ()No Do you drink alcohol? How much? _____
- 27. ()Yes ()No Recent weight loss? Amount lost? _____
- 28. What is your height? _____ Current Weight? _____ Age? _____
- 29. ()Yes ()No Do you smoke or have you ever smoked? Amount per day: _____
- 30. ()Yes ()No Are you on a special diet or using any diet pills? Specify: _____
- 31. ()Yes ()No Are you currently taking any daily medications? Specify: _____
- 32. ()Yes ()No Have you taken medicine such as cortisone or steroids during the past year?
- 33. ()Yes ()No Do you use eye drops? Specify: _____
- 34. ()Yes ()No Do you have glaucoma?
- 35. ()Yes ()No Do you have any problem with frequent heart burn, esophageal reflux, frequent indigestion, or hiatal hernia?

DO YOU HAVE ANY OF THE FOLLOWING:

- () Dentures () Partial Plate () Bridgework Permanent () Caps

DO YOU WEAR ANY OF THE FOLLOWING:

- () Contact Lenses () False Eyelashes () Wig/Hairpiece () Hearing Aid

List medical/surgical problems: _____

List previous surgeries: _____

PATIENT/PARENT SIGNATURE: _____

ANESTHESIOLOGIST SIGNATURE: _____

DATE: _____