Anesthesia
Consultants of Georgia, LLC

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:** _____