

Anesthesia Questionnaire

| |
|------------------------------|
| Reviewers Initials: _____ |
|------------------------------|

Patient Name: _____ Date _____

Weight _____ Height _____ Age _____

Physical Activity Now: Little _____ Moderate _____ Active _____ Very Active _____

Can you climb stairs? Yes _____ No _____ More than one flight _____

YOUR ANESTHESIA HISTORY

What kind of anesthesia have you had? (circle all that apply)

General (Pentotal/Gas) Saddle Block/Spinal Nerve blocks Local injections

YES NO

| | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you or your family had any reactions, problems, or complications with anesthesia? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you allergic to Latex? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you been treated at this facility before? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have removable dentures, caps, loose or chipped teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Wear contact lenses, false eyelashes, false eyes? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have difficulty opening your mouth or moving your head or neck? |

YOUR MEDICAL HISTORY (IF ANSWER IS YES, CIRCLE ALL THAT APPLY)

YES NO

| | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding Tendency, Hepatitis Jaundice Liver Trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | Lung Disease TB Asthma Wheezing Bronchitis Emphysema |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you currently have a Cough Cold |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease Heart Attack-when? _____ Angina Chest Pain Irregular heart beat-what kind? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke-when _____ Epilepsy Convulsions Mental illness Nerve Paralysis Fainting Spell |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure Diabetes Thyroid Disease Glaucoma Sickle Cell Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Present Drug Addiction List Drug(s) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you taken illegal drugs What Drug(s) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke? How much _____ How Often _____ Year Quit _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Drink alcohol? How much _____ How often _____ Alcohol withdrawal? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you taking Aspirin, Blood thinners or NSAIDS? Date of last dose _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you snore? Have sleep apnea? Use C-PAP? Stop breathing during sleep? Daytime tiredness? |
| <input type="checkbox"/> | <input type="checkbox"/> | History of sleep apnea or has anyone observed you stop breathing during sleep? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you allergic to: Medications Foods Soap Tape Latex |

List ALL allergies _____

List Previous Surgery (ies) _____

Your anesthesiologist will talk and advise you regarding the type of anesthesia considered medically advisable. Modern day anesthesia is very safe. However, you should understand that, like other medical procedures, the administration of anesthesia is associated with certain risks. Major complications from anesthesia are extremely rare but they can result in death or disability. Please sign below when you have completed this form to the best of your knowledge and are satisfied you understand its contents.

Signature _____ Relationship _____



Name: _____

Date of Birth: _____

Allergies _____

Medication List

Please complete this form and bring it on your day of surgery.

List the name, strength, how often and reason why you take medications.

Include **all** herbal and non prescription drugs.

Anesthesiologist &
staff initials

| DRUG NAME | STRENGTH | HOW OFTEN | REASON |
|-----------|----------|-----------|--------|
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| NEW MEDICATIONS ADDED TODAY | | |
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Copy given to pt _____ (initials)