PRE-ANESTHESIA QUESTIONNAIRE

INSTRUCTIONS: Please checkmark (□) your answer to each question below. These answers will greatly help us give you the best possible care during your procedure. If you do not know an answer, please indicate by a questions mark (?). If there are multiple answers, please circle the appropriate one. Be specific and explain if necessary.

AGE_____ **SEX**_____ **HEIGHT**_____ **WEIGHT**_____
MEDICATION ALLERGIES_____ **REACTION**_____

ARE YOU ALLERGIC TO LATEX? ☐ YES ☐ NO REACTION: _____

Have you or anyone in your family had an unusual reaction to Anesthesia? ☐ YES ☐ NO
If YES, explain: _____
List any medications that you take, including blood thinners (Aspirin, Ibuprofen, Plavix, Coumadin, etc)?

_____
_____

***Please complete the MEDICATION RECONCILIATION SHEET that is included in this packet.**

Are you taking any herbal medications? ☐ YES ☐ NO If YES, please list: _____

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

Question	Yes	No	Question	Yes	No
Are you a diabetic?	☐	☐	Palpitations: Irregular or fast heartbeat?	☐	☐
Do you currently have a cold?	☐	☐	Any blood diseases?	☐	☐
Do you have bronchitis or a chronic cough?	☐	☐	Jaundice, Hepatitis, Liver Trouble?	☐	☐
Do you have Asthma?	☐	☐	Gallbladder trouble?	☐	☐
Do you have Emphysema?	☐	☐	Do you drink alcoholic beverages? How much alcohol/beer in a week? _____	☐	☐
Do you have shortness of breath?	☐	☐	Gastric-esophageal problems?	☐	☐
Do you have any other lung trouble? If yes, explain:	☐	☐	Reflux-frequent indigestion?	☐	☐
Do you smoke? If so how many cigarettes per day? _____	☐	☐	Hiatal Hernia?	☐	☐
Rheumatic Fever?	☐	☐	Seizure disorder?	☐	☐
Heart Murmur?	☐	☐	Neurological problems?	☐	☐
Any heart valve problems?	☐	☐	Stroke, paralysis, severe head injury?	☐	☐
High blood pressure?	☐	☐	Head or neck injury or surgery?	☐	☐
Do you have a pacemaker? Rate? _____	☐	☐	Back trouble? If yes, for how long?	☐	☐
Chest Pain?	☐	☐	Kidney Trouble?	☐	☐
Heart Attack(s)?	☐	☐	Any history of street drug use?	☐	☐

Any illness or disease not listed above? ☐ Yes ☐ No If yes, please specify: _____

Have you had surgery before? ☐ Yes ☐ No If yes, please specify the surgery below:

☐ Appendectomy ☐ Breast/Biopsy ☐ Cataracts ☐ Gallbladder ☐ Hernia ☐ Hysterectomy

☐ Sinus / Nasal ☐ Tonsils / Adenoids ☐ Orthopedic: _____ ☐ Other: _____

Please list any information you feel would be helpful for your care?

_____
_____

Signature: _____ Date: _____

Cell phone number: _____

Place Patient Label Here