Anesthesia Questionnaire

Patient's Name ____ DOB ____________ Sex: M or F

Planned Operation ___________________________________ Date of Surgery ________________

Surgeon ____________________________________ Primary Doctor _________________________

Cardiologist ____________________ Last visit __________ Office Location ____________________

Any recent significant weight loss/gain:

☐ **Yes** ☐ **No** **Weight_________ Height____________**

Medical History *(Please check all that apply.)*

CARDIAC: ☐ heart attack ☐ heart failure ☐ palpitations ☐ atrial fibrillation

☐ skipped beats ☐ angina (chest pain) ☐ heart murmur ☐ high blood pressure

☐ Pacemaker (bring card) ☐ MVP - Mitral Valve Prolapse

☐ AiCD defibrillator (bring card) If AiCD, has it ever "fired"? ☐ Yes ☐ No

☐ echocardiogram: When: ____________ Where: _________________ Contact Info: ________________

☐ stress test: When: ____________ Where: _________________ Contact Info: ____________________

☐ last EKG: When: ____________ Where: _________________ Contact Info: ____________________

If you have had any of the above "Cardiac Events", please explain: ________________________________

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Can you walk up two flights of stairs without stopping? ☐ Yes ☐ No

Do any physical limitations affect your daily activities? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No If yes, what type? __________________ How often? ______________

PULMONARY: ☐ COPD ☐ asthma ☐ emphysema ☐ TB ☐ sleep apnea ☐ CPAP machine

☐ pneumonia/bronchitis When: ____

☐ have taken steroids When: ____

Are you/were you recently ill with a cold, fever, chills, flu or cough? ☐ Yes ☐ No

Explain: ____

NEUROLOGY: *Please explain details of neurological event(s).*

☐ stroke ______________________________ ☐ difficulty speaking? _____________________________

☐ facial/leg/arm weakness? ____

☐ hearing/vision/memory loss? ____

☐ seizures, epilepsy or fits? ____

☐ nerve stimulator When placed: _________ Is it functioning? ☐ Yes ☐ No ☐ headache

GASTROENTEROLOGY: ☐ reflux/indigestion ☐ ulcers ☐ hiatal hernia

☐ difficulty swallowing

KIDNEY: ☐ kidney stones ☐ kidney failure ☐ dialysis ☐ shunts

☐ prostate enlargement or cancer

Explain: ____

ENDOCRINOLOGY: ☐ *thyroid:* ☐ overactive ***or*** ☐ underactive

☐ *diabetes:* ☐ Type I ☐ Type II ☐ Insulin ☐ Oral Medication

☐ liver disease ☐ hepatitis ☐ cirrhosis ☐ jaundice ☐ cancer

Have you ever been treated for cancer with: ☐ chemotherapy ☐ radiation therapy ☐ surgery

When? ___________ Where? _______________________________Oncologist: _________________________

What type of chemotherapy? ____

HEMATOLOGY: ☐ anemia ☐ leukemia ☐ sickle cell disease ☐ blood clots ☐ transfusions

☐ prolonged bleeding ☐ bleeding disorders (hemophilia)

Do you have strong beliefs that would preclude you from accepting blood products; if deemed necessary? ☐ Yes ☐ No

If you or a family member has had any of the above "Hematology Events", please explain:

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MUSCLE/Problem with: ☐ back ☐ bone ☐ muscle ☐ neck ☐ TMJ ☐ range of motion

☐ rheumatoid arthritis

SKELATAL: ☐ Osteoarthritis

If you have had any of the above "Orthopedic Events", please explain: ________________________

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OB/GYN: Pregnant? ☐ Yes ☐ No Last menstrual period began: __________________________

SOCIAL: ☐ smoke # packs/day ________ # years _______ quit/when __________________________

☐ drink alcohol, daily amount: ____

☐ recreational drugs, if yes, what kind: ____

ANESTHESIA: ☐ severe nausea or vomiting ☐ breathing difficulties ☐ slow to wake up

☐ adverse reaction ☐ history of difficult intubation ☐ pseudo cholinesterase deficiency

☐ malignant hyperthermia (in blood relatives or self)

If you have had any of the above "Anesthesia Events", please explain: ________________________

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AIRWAY/TEETH ☐ chipped or loose teeth ☐ dentures ☐ caps ☐ braces ☐ bridgework

☐ problems swallowing or choking ☐ problems opening your mouth

Please list **ALL OPERATIONS** (and approximate dates) and reasons for such surgeries:

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Please list any **ALLERGIES** to medicines, latex, foods or other, and your reaction to it:

____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

Please list **ALL MEDICATIONS** you have taken in the last month. Include OVER THE COUNTER drugs, inhalers, herbals, dietary supplements, vitamins, and aspirin.

Name of Drug	**Dose & Frequency**	**Name of Drug**	**Dose & Frequency**
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________

Please list any medical illnesses not noted above:

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Additional comments/questions for Anesthesiologist:

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