

Pre-Anesthesia Patient Questionnaire

Patient's Name: _____

Date: _____

Please answer the following questions so that we can provide the anesthetic that is best for you. The Anesthetist providing your care will be happy to assist you and provide you with information about the risks and benefits of the proposed anesthetic.

Body Weight: _____ **Body Height:** _____

Previous Operations/Dates:

Drug Allergies:

Current Medications:

Women:

Last Menstrual Period (LMP): _____

Please Circle YES or NO for each question: (ALL questions Must be answered)

- | | | |
|---|-----|----|
| 1. Do you have heart troubles? | YES | NO |
| Explain _____ | | |
| 2. Do you take heart or blood pressure medications? | YES | NO |
| 3. Do you get pains in your chest when you exercise? | YES | NO |
| 4. Do you get pains in your chest when you rest? | YES | NO |
| 5. Do you have troubles breathing? | YES | NO |
| 6. Do you have bronchitis or a chronic cough? | YES | NO |
| 7. Do you feel short of breath at times? | YES | NO |
| 8. Is it difficult for you to climb stairs? | YES | NO |
| 9. Do you or did you smoke? | YES | NO |
| If yes, packs per day _____ and number of years _____ | | |

- | | | |
|--|-----|----|
| 10. Do you drink alcohol on a regular basis?
How much/how often _____ | YES | NO |
| 11. Do you have diabetes?
Insulin: _____ Other meds: _____ | YES | NO |
| 12. Have you had Hepatitis, liver disease, or yellow jaundice?
When _____ | YES | NO |
| 13. Have you had Kidney disease? | YES | NO |
| 14. Do you have ulcers or stomach problems?
Explain _____ | YES | NO |
| 15. Do you have a hiatal hernia? | YES | NO |
| 16. Do you have constant back or neck pain? | YES | NO |
| 17. Do you have any limb paralysis, numbness or weakness?
Explain: _____ | YES | NO |
| 18. Do you have any muscle or nerve diseases? | YES | NO |
| 19. Do you have arthritis?
Where? _____ | YES | NO |
| 20. Do you ever have trouble with any anesthesia in the past?
Explain: _____ | YES | NO |
| 21. Have any of your blood relatives had problems with anesthesia in the past?
Explain? _____ | YES | NO |
| 22. Do you have any bleeding problems? | YES | NO |
| 23. Have you had a blood transfusion? | YES | NO |
| 24. Do you have loose, chipped, false teeth, or bridgework? | YES | NO |
| 25. Have you taken cortisone in the past 6 months? | YES | NO |
| 26. Do you get claustrophobia? | YES | NO |
| 27. Do you have thyroid problems? | YES | NO |

Anesthetist &/or Doctor's Signature

Date