

**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:**


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**Drug Allergies:**


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**Current Medications:**


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**Women:**

Last Menstrual Period (LMP): \_\_\_\_\_

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

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|---|-----|----|
| 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? YES NO  
How much/how often \_\_\_\_\_
11. Do you have diabetes? YES NO  
Insulin: \_\_\_\_\_ Other meds: \_\_\_\_\_
12. Have you had Hepatitis, liver disease, or yellow jaundice? YES NO  
When \_\_\_\_\_
13. Have you had Kidney disease? YES NO
14. Do you have ulcers or stomach problems? YES NO  
Explain \_\_\_\_\_
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? YES NO  
Explain: \_\_\_\_\_
18. Do you have any muscle or nerve diseases? YES NO
19. Do you have arthritis? YES NO  
Where? \_\_\_\_\_
20. Do you ever have trouble with any anesthesia in the past? YES NO  
Explain: \_\_\_\_\_
21. Have any of your blood relatives had problems with anesthesia in the past? YES NO  
Explain? \_\_\_\_\_
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

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**Anesthetist &/or Doctor's Signature**

**Date**