



# ANESTHESIA QUESTIONNAIRE

Date: \_\_\_\_\_ Day Phone: \_\_\_\_\_ Eve Phone: \_\_\_\_\_

1.  See Universal Medication List
2. List all PREVIOUS SURGERIES, dates, and complications if any.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of your Primary Care Physician/Fax # \_\_\_\_\_ Date of last checkup \_\_\_\_\_ Date of last Chest X-ray/where \_\_\_\_\_ Date of last EKG/where \_\_\_\_\_

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	3. Were there any complications with the anesthesia? Explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	4. Were you told it was difficult to insert the breathing tube?
<input type="checkbox"/>	<input type="checkbox"/>	5. Have any of your blood relatives had problems with anesthesia? (e.g. high fevers, difficulty awakening)
<input type="checkbox"/>	<input type="checkbox"/>	6. Do you have allergies to any medications? List: _____
<input type="checkbox"/>	<input type="checkbox"/>	Shellfish? or Iodine? (Circle one if applicable) Reactions: _____
<input type="checkbox"/>	<input type="checkbox"/>	7. Do you have problems with your heart or blood vessels?
<input type="checkbox"/>	<input type="checkbox"/>	previous heart attack? Date: _____
<input type="checkbox"/>	<input type="checkbox"/>	chest pain/angina?
<input type="checkbox"/>	<input type="checkbox"/>	skipped heart beats or palpitations? mitral valve prolapse?
<input type="checkbox"/>	<input type="checkbox"/>	heart failure, pacemaker or implanted cardiac defibrillator (ICD)?
<input type="checkbox"/>	<input type="checkbox"/>	Have you had an increase in severity or frequency of your heart symptoms over the past year?
<input type="checkbox"/>	<input type="checkbox"/>	8. Have you been hospitalized for any of these heart problems? When: _____ Explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	9. Have you had a recent stress test or other special heart test? When: _____ Where: _____
		Results: _____
<input type="checkbox"/>	<input type="checkbox"/>	10. Have you ever been told you have high blood pressure? For how long? _____
<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever had a stroke or partial stroke? When: _____ Results: _____
<input type="checkbox"/>	<input type="checkbox"/>	12. Recreation drugs? When? _____ # of years _____ Date Stopped: _____
<input type="checkbox"/>	<input type="checkbox"/>	13. Do you have problems with your lungs or chest?
<input type="checkbox"/>	<input type="checkbox"/>	Past/Present tobacco use? How many per day? _____ # years? _____ When quit? _____
<input type="checkbox"/>	<input type="checkbox"/>	shortness of breath or cough productive of sputum?
<input type="checkbox"/>	<input type="checkbox"/>	emphysema/bronchitis/asthma/sleep apnea? (Circle) Any wheezing this week? _____
<input type="checkbox"/>	<input type="checkbox"/>	ever been hospitalized for emphysema or asthma?
<input type="checkbox"/>	<input type="checkbox"/>	14. Have you had fever, chills, cold, or flu within the past week?
<input type="checkbox"/>	<input type="checkbox"/>	15. Do you have any problems with your: (Circle those which apply & give dates)
<input type="checkbox"/>	<input type="checkbox"/>	liver (cirrhosis, hepatitis, jaundice, alcoholism)? _____
<input type="checkbox"/>	<input type="checkbox"/>	kidneys (stones, infection, failure, dialysis)? _____
<input type="checkbox"/>	<input type="checkbox"/>	blood (anemia, leukemia, sickle cell)? _____
<input type="checkbox"/>	<input type="checkbox"/>	thyroid gland (over or under active)? _____
<input type="checkbox"/>	<input type="checkbox"/>	16. Have you ever been told you have sugar diabetes? For how long? _____
<input type="checkbox"/>	<input type="checkbox"/>	17. Do you have epilepsy or suffer from fits or seizures? For how long? _____
<input type="checkbox"/>	<input type="checkbox"/>	18. Do you have frequent heartburn/indigestion, acid reflux from your stomach, or hiatal hernia? (Circle if applicable)
<input type="checkbox"/>	<input type="checkbox"/>	19. Have you ever had a blood transfusion? When? _____
<input type="checkbox"/>	<input type="checkbox"/>	20. Could you have any blood infections such as HIV or Hepatitis B/C?
<input type="checkbox"/>	<input type="checkbox"/>	21. Have you or any blood relatives ever had a serious bleeding problem (e.g. hemophilia, bruising)?
<input type="checkbox"/>	<input type="checkbox"/>	22. Do you have false teeth or oral jewelry? (Circle if applicable)
<input type="checkbox"/>	<input type="checkbox"/>	23. Do you have neck or back problems (e.g. arthritis in neck, herniated disc, surgery)?
<input type="checkbox"/>	<input type="checkbox"/>	24. Are you or could you be pregnant?
<input type="checkbox"/>	<input type="checkbox"/>	25. Date of your last period _____ Tubal? _____ Hysterectomy? _____
<input type="checkbox"/>	<input type="checkbox"/>	26. Would you like to be tested for possible pregnancy?
<input type="checkbox"/>	<input type="checkbox"/>	27. Do you have any other health problems? Explain: _____

Based on the information given by you certain additional tests may be ordered, i.e. drug screen, medication levels, chest x-ray, etc.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_