



ANESTHESIA QUESTIONNAIRE

AGE	HEIGHT	WEIGHT	PRIMARY CARE PHYSICIAN
REASON FOR ADMISSION/ NAME OF PROCEDURE		PROCEDURE DATE	SURGEON/ DOCTOR

YOUR ANESTHESIA TODAY WILL BE ADMINISTERED BY _____ MD/CRNA PT INITIALS _____

Y	N	SPECIAL CONSIDERATIONS	I HAVE DISCUSSED WITH MY SURGEON: THE NECESSITY AND APPROPRIATENESS OF THE PROPOSED SURGERY AS WELL AS ALTERNATIVE TREATMENTS
		COMMUNICATION PROBLEMS (VISION, HEARING) PHYSICAL LIMITATIONS MEDICATION ALLERGIES <input type="checkbox"/> NONE <input type="checkbox"/> SEE MED/ALLERGY HISTORY FORM FOOD & OTHER ALLERGIES <input type="checkbox"/> NONE <input type="checkbox"/> SEE MED/ALLERGY HISTORY FORM	<input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:

PREVIOUS HOSPITALIZATIONS OR OPERATIONS (INDICATE APPROXIMATE YEAR)	CURRENT AND RECENT MEDICATIONS
	<input type="checkbox"/> I DO NOT CURRENTLY TAKE ANY MEDICATIONS (PRESCRIPTION OR OVER THE COUNTER), VITAMINS OR HERBS <input type="checkbox"/> SEE MEDICATION/ALLERGY HISTORY FORM

HAVE YOU HAD A BAD REACTION TO ANESTHESIA? YES NO
 HAS A BLOOD RELATIVE HAD A BAD REACTION TO ANESTHESIA? YES NO

	DO YOU CURRENTLY OR HAVE YOU HAD:	Y	N		Y	N
HEALTH HISTORY	DIABETES			HAVE YOU HAD ANY ILLNESS, COLD, COUGH OR FEVER WITHIN THE LAST WEEK?		
	HYPOGLYCEMIA (LOW BLOOD SUGAR)			HAVE YOU HAD RECENT EXPOSURE TO ANY COMMUNICABLE DISEASES?		
	THYROID PROBLEMS			IS THERE A POSSIBILITY YOU ARE PREGNANT? LAST MENSTRUAL PERIOD		
	HEART PROBLEMS (RHEUMATIC FEVER, MURMUR, CHEST PAIN, HEART ATTACK, IRREGULAR HEARTBEAT, EKG CHANGES, ANGINA, ANKLE SWELLING, VALVE REPLACEMENT)			DO YOU HAVE A HISTORY OF SMOKING? PACKS PER DAY DATE QUIT		
	BLOOD CLOTS, TRANSFUSION PROBLEMS			DO YOU DRINK ALCOHOLIC BEVERAGES? HOW OFTEN? HOW MUCH?		
	BLEEDING TENDENCY (HEMOPHILIA)			DO YOU HAVE HISTORY OF, OR ARE YOU TAKING, ANY RECREATIONAL DRUGS?		
	HIGH BLOOD PRESSURE			DO YOU HAVE ANY OF THE FOLLOWING: <input type="checkbox"/> FALSE TEETH <input type="checkbox"/> BRIDGES <input type="checkbox"/> RETAINERS <input type="checkbox"/> BRACES <input type="checkbox"/> LOOSE TEETH <input type="checkbox"/> CAPPED TEETH <input type="checkbox"/> CHIPPED TEETH		
	STROKE (WEAKNESS OR NUMBNESS ON ONE SIDE, DIFFICULTY SPEAKING, LOSS OF VISION)			DO YOU WEAR CONTACT LENSES?		
	SEIZURES (EPILEPSY, CONVULSIONS, BLACKOUTS)			ARE THERE ANY PAIN MEDICATIONS YOU CANNOT TAKE? (LIST)		
	SEVERE HEADACHES			WOULD YOU LIKE TO DISCUSS ANY CONCERNS OR FEARS REGARDING THIS PROCEDURE?		
	LUNG PROBLEMS (ASTHMA, CHRONIC COUGH, PNEUMONIA, WHEEZING, SHORTNESS OF BREATH, EMPHYSEMA, ABNORMAL CHEST X-RAY)			HAVE YOU MADE ARRANGEMENTS FOR ASSISTANCE AFTER YOUR SURGERY?		
	TUBERCULOSIS (TB)			DO YOU NEED A RELEASE FOR WORK OR SCHOOL?		
	SLEEP APNEA (BREATHING INTERRUPTION DURING SLEEPING)			IF THE PATIENT IS A CHILD		
	LIVER PROBLEMS (JAUNDICE, HEPATITIS)			WAS THE CHILD PREMATURE?		
	KIDNEY, BLADDER OR PROSTATE PROBLEMS (INFECTIONS)			ANY BIRTH DEFECTS OR DEVELOPMENTAL ISSUES?		
	STOMACH PROBLEMS (ULCER, HIATAL HERNIA, REFLUX, HEARTBURN)			ANY IMMUNIZATION PROBLEMS OR DELAY?		
	BOWEL PROBLEMS (IRRITABLE BOWEL, DIVERTICULITIS)			ANY HISTORY OF BREATH HOLDING, BREATHING PROBLEMS OR CROUP?		
	BACK OR NECK OR BROKEN BONES IN SPINE (STRAIN, DISC PROBLEMS, NUMBNESS OR TINGLING OF HANDS)					
	ARE YOU RECEIVING TREATMENT FOR GLAUCOMA					
	RESTRICTIONS IN MOVEMENT					
DIFFICULTY OPENING MOUTH (TMJ)						
ARTHRITIS						
MUSCLE DISORDERS (MD, MYASTHENIA GRAVIS)						
CANCER						
MENTAL HEALTH ISSUES/PHOBIAS						
SKIN DISORDERS (ECZEMA)						
OTHER MEDICAL PROBLEMS/PARKINSON'S DISEASE						

COMMENTS:	PATIENT/SO SIGNATURE X _____
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INFORMATION ABOVE THE DOUBLE LINE MAY BE FOUND ON THE PATIENT HISTORY

PATIENT HISTORY REVIEWED BY ANESTHETIST

NPO SINCE:		
OPERATION PROPOSED		
ANESTHESIA		
ANESTHESIA FAMILY HISTORY		
ALLERGIES		
MEDICATIONS		
CARDIOVASCULAR		
PULMONARY		
GI/HEPATIC		
RENAL		
CNS		
ENDOCRINE		
REMARKS		
PRE-PROCEDURE VITALS REVIEWED <input type="checkbox"/>		
	HEENT	DENTITION
	NECK	
	CHEST	
	COR	
LAB:	HCT	OTHER
STATUS	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	
PLAN	<input type="checkbox"/> MAC <input type="checkbox"/> GETA <input type="checkbox"/> GA <input type="checkbox"/> SAB <input type="checkbox"/> EPIDURAL <input type="checkbox"/> IV REGIONAL <input type="checkbox"/> IV SEDATION	
POSSIBLE COMPLICATIONS EXPLAINED, QUESTIONS ANSWERED <input type="checkbox"/> YES <input type="checkbox"/> NO		
<input type="checkbox"/> RISKS, BENEFITS & ALTERNATIVES EXPLAINED		
SIGNED	DATE	TIME

ANESTHESIA PROGRESS NOTES