ST. GEORGE SURGICAL CENTER

Patient Sticker
REVISED 1/2016

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
		COMMUNICATION PROBLEMS (VISION, HEARING)
		PHYSICAL LIMITATIONS
		MEDICATION ALLERGIES ☐ NONE ☐ SEE MED/ALLERGY HISTORY FORM
		FOOD & OTHER ALLERGIES ☐ NONE ☐ SEE MED/ALLERGY HISTORY FORM

I HAVE DISCUSSED WITH MY SURGEON: THE NECESSITY AND APPROPRIATENESS OF THE PROPOSED SURGERY AS WELL AS ALTERNATIVE TREATMENTS
☐ YES ☐ NO COMMENTS:

PREVIOUS HOSPITALIZATIONS OR OPERATIONS (INDICATE APPROXIMATE YEAR)	CURRENT AND RECENT MEDICATIONS
	☐ I DO NOT CURRENTLY TAKE ANY MEDICATIONS (PRESCRIPTION OR OVER THE COUNTER), VITAMINS OR HERBS
	☐ 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**

HISTORY

DO YOU CURRENTLY OR HAVE YOU HAD:	Y	N
DIABETES		
HYPOGLYCEMIA (LOW BLOOD SUGAR)		
THYROID PROBLEMS		
HEART PROBLEMS (RHEUMATIC FEVER, MURMUR, CHEST PAIN, HEART ATTACK, IRREGULAR HEARTBEAT, EKG CHANGES, ANGINA, ANKLE SWELLING, VALVE REPLACEMENT)		
BLOOD CLOTS, TRANSFUSION PROBLEMS		
BLEEDING TENDENCY (HEMOPHILIA)		
HIGH BLOOD PRESSURE		
STROKE (WEAKNESS OR NUMBNESS ON ONE SIDE, DIFFICULTY SPEAKING, LOSS OF VISION)		
SEIZURES (EPILEPSY, CONVULSIONS, BLACKOUTS)		
SEVERE HEADACHES		
LUNG PROBLEMS (ASTHMA, CHRONIC COUGH, PNEUMONIA, WHEEZING, SHORTNESS OF BREATH, EMPHYSEMA, ABNORMAL CHEST X-RAY)		
TUBERCULOSIS (TB)		
SLEEP APNEA (BREATHING INTERRUPTION DURING SLEEPING)		
LIVER PROBLEMS (JAUNDICE, HEPATITIS)		
KIDNEY, BLADDER OR PROSTATE PROBLEMS (INFECTIONS)		
STOMACH PROBLEMS (ULCER, HIATAL HERNIA, REFLUX, HEARTBURN)		
BOWEL PROBLEMS (IRRITABLE BOWEL, DIVERTICULITIS)		
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		

HEALTH

	Y	N
HAVE YOU HAD ANY ILLNESS, COLD, COUGH OR FEVER WITHIN THE LAST WEEK?		
HAVE YOU HAD RECENT EXPOSURE TO ANY COMMUNICABLE DISEASES?		
IS THERE A POSSIBILITY YOU ARE PREGNANT? LAST MENSTRUAL PERIOD		
DO YOU HAVE A HISTORY OF SMOKING? PACKS PER DAY DATE QUIT		
DO YOU DRINK ALCOHOLIC BEVERAGES? HOW OFTEN? HOW MUCH?		
DO YOU HAVE HISTORY OF, OR ARE YOU TAKING, ANY RECREATIONAL DRUGS?		
DO YOU HAVE ANY OF THE FOLLOWING: ☐ FALSE TEETH ☐ BRIDGES ☐ RETAINERS ☐ BRACES ☐ LOOSE TEETH ☐ CAPPED TEETH ☐ CHIPPED TEETH		
DO YOU WEAR CONTACT LENSES?		
ARE THERE ANY PAIN MEDICATIONS YOU CANNOT TAKE? (LIST)		
WOULD YOU LIKE TO DISCUSS ANY CONCERNS OR FEARS REGARDING THIS PROCEDURE?		
HAVE YOU MADE ARRANGEMENTS FOR ASSISTANCE AFTER YOUR SURGERY?		
DO YOU NEED A RELEASE FOR WORK OR SCHOOL?		
IF THE PATIENT IS A CHILD		
WAS THE CHILD PREMATURE?		
ANY BIRTH DEFECTS OR DEVELOPMENTAL ISSUES?		
ANY IMMUNIZATION PROBLEMS OR DELAY?		
ANY HISTORY OF BREATH HOLDING, BREATHING PROBLEMS OR CROUP?		

COMMENTS:

PATIENT/SO SIGNATURE X _____