PREANESTHETIC QUESTIONNAIRE

This questionnaire is designed to assist the staff who will be taking care of you. It will help us to learn more about your health. Please fill it out as completely as possible and return it to the reception desk.

Name: ________________________________________________________  Age:________  Sex:  □ Male

Male

Height: __________  Weight:________  Occupation: _____________________________________________________

Female

Please leave the number you can be reached the night before surgery: __________________________________________

Referring Surgeon:_____________________ Type of operation:_______________________ Date of Surgery:_________

Have you been a patient in this pre-operative anesthesia clinic in the past 3 months?  □ Yes  □ No

What kind of physical exercise do you do? (i.e., walk, run, bike, etc. or none)____________________________________

Previous Surgery:

<table>
<thead>
<tr>
<th>Year of Surgery</th>
<th>Type of Operation</th>
<th>General or Local</th>
<th>Problem(s)</th>
<th>Complications</th>
<th>Explain</th>
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Have you ever been hospitalized for an illness not requiring surgery:

1._______________________________________________________________________________________________

2._______________________________________________________________________________________________

3._______________________________________________________________________________________________

Do you have or have you ever had any of these problems: (Please circle)

1. Heart problems of any kind
2. Stroke
3. Kidney or bladder problems
4. Liver problems or hepatitis
5. High blood pressure
6. Diabetes
7. Bleeding problem
8. Cancer
9. Seizure or epilepsy
10. Rheumatic fever
11. Rheumatoid arthritis
12. Lung problem (e.g., pneumonia, emphysema, asthma)
13. Blood transfusion
14. Tuberculosis (TB)
15. Thyroid disease (or problems)
16. Gastroesophageal Reflux disease/ Hiatal hernia
17. Sleep Anea
18. Date of last menstrual period
19. Other:__________________________

Please name any medicines that you are presently taking; include all prescription and non-prescription drugs (even aspirin):

Name of medication | Dosage (amount) | Number of times taken each day
1.__________________________

2.__________________________

3.__________________________
Are you allergic to, or have you had unusual reactions to medications, adhesive tape, foods or latex? Please list the items and the type of reaction you experienced.

___________________________________________________________________________________________________________

Have you taken steroids such as prednisone or cortisone? ☐ Yes ☐ No

If so, when? ____________________________________________________

Do you have any of the following: (Please circle)

☐ false teeth, ☐ capped teeth, ☐ loose teeth, ☐ braces, ☐ chipped teeth

or teeth that need dental care, specify ____________________________________________________________

Have you or any of your close relatives had problems or complications with anesthesia? ☐ Yes ☐ No

If so, what? __________________________________________________________

Did your doctor ask you to donate your own blood for surgery? ☐ Yes ☐ No How many units? ________

At the present time, do you have? (Please check appropriate boxes)

☐ chest pain
☐ blackouts or periods of dizziness
☐ palpitations or irregular heart beats
☐ pain in your legs with exercise
☐ ankle swelling
☐ shortness of breath at night
☐ shortness of breath while walking up one flight of stairs
☐ chronic cough or sputum (phlegm)
☐ blood in your sputum
☐ black or tarry stools, diarrhea
☐ frequent nausea and vomiting
☐ temporary loss or blurring of vision
☐ temporary weakness of one or more limbs
☐ facial weakness, numbness
☐ burning with urination or frequent urination
☐ arthritis or severe joint pains
☐ back pain or neck pain
☐ excessive bleeding following minor cuts or dental surgery
☐ recent weight loss
☐ difficulty walking
☐ pregnancy
☐ acid reflex symptoms
☐ heart murmur

Have you had any problems in the last two weeks with: (Please circle)

☐ A "cold," ☐ "flu," ☐ bronchitis, ☐ laryngitis, ☐ sore throat, ☐ fever

Have you ever smoked? ☐ Yes ☐ No If yes, at worst, how many packs per day? ____________________________

How many years? __________ If you quit, when? ________________

Do you drink alcoholic beverages? ☐ Yes ☐ No How often? ________________ How much? ________________

Do you use “recreational” or illegal drugs? ☐ Yes ☐ No Type____________________________________________________

Questions for anesthesiologist:

1. __________________________________________________________________________________________

2. __________________________________________________________________________________________

Patient / Guardian Signature: ____________________________ Date: ____________________________

THANK YOU !!!!