Anesthesia Pre-Operative Questionnaire

Patient Name	Sex	Age	Height	Weight

Yes No

☐ ☐ Previous surgery/anesthesia? List what & when ______________________________

☐ ☐ Have you, or a blood relative, had any problems with anesthesia, including: nausea, weakness, difficulty breathing or high fever? If yes, explain: ______________________________

☐ ☐ Do you have an advanced medical directive?

☐ ☐ Would you like information about medical directives?

For Children under age 18:

Yes No

☐ ☐ Premature birth

☐ ☐ Breathing problems after birth

☐ ☐ Other conditions being treated for: __________ ______________________________

Yes No

☐ ☐ Heart problems after birth

☐ ☐ Respiratory illness in the past month

☐ ☐ Family history of muscle disease

For Ages 18 and Older:

Yes No

☐ ☐ Heart attack–when ____________________

☐ ☐ Heart surgery-If yes, what & when ___________ ______________________________

☐ ☐ Pacemaker/internal defibrillator

☐ ☐ Congestive heart failure

☐ ☐ Angina/chest pain

☐ ☐ Heart murmur requiring treatment

☐ ☐ Irregular heartbeat

☐ ☐ Last EKG: when & where________________

☐ ☐ High blood pressure

☐ ☐ Elevated cholesterol

☐ ☐ Fainting spells

☐ ☐ Shortness of breath

☐ ☐ Asthma/wheezing

☐ ☐ Emphysema/chronic bronchitis or/lung disease

☐ ☐ Have you ever had a Sleep Study

☐ ☐ Been told you stop breathing while you sleep

☐ ☐ Frequent morning headaches

☐ ☐ Fall asleep easily during the day

☐ ☐ Have you been diagnosed with Sleep Apnea

☐ ☐ Been prescribed CPAP/BiPAP machine

☐ ☐ Do you use the CPAP/BiPAP machine

Setting ____________________

☐ ☐ Do you snore loudly

☐ ☐ Back/neck surgery or problems

☐ ☐ Arthritis requiring treatment

☐ ☐ Problems opening mouth (TMJ)

☐ ☐ Numbness/weakness of muscles-If yes, where ______________________________

Yes No

☐ ☐ Chronic pain

☐ ☐ Thyroid disorder

☐ ☐ Stroke – when ______________________________

☐ ☐ Seizures – type ______________________________

☐ ☐ Frequent heartburn, hiatal hernia, reflux

☐ ☐ Diabetes/glucose intolerance

average morning blood sugar _______________

☐ ☐ Bleeding problems/blood clots

☐ ☐ Family history of blood clots

☐ ☐ Sickle cell disease or trait

☐ ☐ Hepatitis or jaundice

☐ ☐ Cancer – of what & when________________

☐ ☐ Kidney disease/dialysis

☐ ☐ Mediport, portacath, vein shunt

☐ ☐ Prosthesis/implants ______________________

☐ ☐ Body piercings/jewelry

☐ ☐ A communicable disease (i.e., TB, HIV, VD, Hepatitis, MRSA, VRE)

Type ______________________________

☐ ☐ Are you pregnant? Last menstrual period ___________

☐ ☐ Are you currently taking birth control pills?

☐ ☐ Tobacco products: what/how often: _______________ ______________________________

☐ ☐ Vaping products: what/how often: ________________

☐ ☐ Ever smoked in the past? If yes, quit when? ________

☐ ☐ Drink alcohol regularly/how much? _______________

☐ ☐ Object to blood transfusions

☐ ☐ Dentures/partials/loose or chipped teeth

☐ ☐ Other conditions being treated for _______________ ______________________________

What is the most activity you can do before you get tired or short of breath and have to stop?

☐ Walk across room ☐ Walk one block ☐ Walk one mile ☐ Run a mile

If one block or less, what limits your activity? ______________________________

Any other information you feel the anesthesiologist should know? ______________________________

Patient Label

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