

ANESTHESIA PREOPERATIVE QUESTIONNAIRE

SURGERY DATE:	SURGEON:	TYPE OF SURGERY:
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PATIENT NAME	AGE:	HEIGHT:	WEIGHT:
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LIST ALL PREVIOUS SURGERIES OR PROCEDURES REQUIRING SEDATION:

YES NO **HAVE YOU, OR A BLOOD RELATIVE HAD ANY PROBLEMS WITH ANESTHESIA INCLUDING NAUSEA, WEAKNESS, DIFFICULTY BREATHING OR HIGH FEVER?**

IF YES, PLEASE DESCRIBE:

FOR CHILDREN UNDER AGE 18:

- YES NO Premature Birth
- YES NO Breathing problems after birth
- YES NO Heart problems after birth
- YES NO Respiratory illness in past month
- YES NO Family history of muscle disease
- YES NO Other conditions being treated for:

For ages 18 and Older:

- | | |
|--|---|
| <input type="checkbox"/> YES <input type="checkbox"/> NO High Blood Pressure | <input type="checkbox"/> YES <input type="checkbox"/> NO Elevated Cholesterol |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Heart Attack When? _____ | <input type="checkbox"/> YES <input type="checkbox"/> NO Irregular Heart Beat |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Heart Surgery When? _____
Where? _____ | <input type="checkbox"/> YES <input type="checkbox"/> NO Heart Valve Disease,
Describe _____ |

YES NO EKG
When _____ Where _____

GLANDS

- | | |
|---|---|
| <input type="checkbox"/> YES <input type="checkbox"/> NO Pacemaker/Internal Defibrillator | <input type="checkbox"/> YES <input type="checkbox"/> NO Diabetes Average Morning Blood Sugar _____ |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Congestive Heart Failure | <input type="checkbox"/> YES <input type="checkbox"/> NO Glucose Intolerance |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Angina/Chest Pain | <input type="checkbox"/> YES <input type="checkbox"/> NO Hypoglycemia/ Low Blood Sugar |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Heart Murmur requiring treatment | <input type="checkbox"/> YES <input type="checkbox"/> NO Thyroid Disorder |

BREATHING/RESPIRATORY

- YES NO Shortness of Breath
- YES NO Asthma or Wheezing
- YES NO Emphysema
- YES NO Lung Disease
- YES NO Chronic Bronchitis
- YES NO Snore or Been told you stop breathing while you sleep
- YES NO Sleep Apnea
- YES NO Frequent morning headaches or fall asleep easily during the day
- YES NO Use or been prescribed a CPAP or BiPAP machine
- YES NO Smoke? Packs per Day? _____
- YES NO Smoked in the past? Year you quit _____

MUSCLES AND BONES

- YES NO Arthritis requiring treatment
- YES NO Problems opening mouth/ TMJ
- YES NO Back or Neck Problems Describe _____
- YES NO Back or Neck Surgery, Describe _____
- YES NO Numbness or weakness of muscles
Where? _____
- YES NO Chronic pain, Location _____

BRAIN

- YES NO Seizures, If yes what type? _____
Date of Last Seizure? _____
- YES NO Stroke or Mini Stroke/ TIA If yes, When? _____
- YES NO Fainting Spells

ABDOMEN AND KIDNEYS

- | | |
|---|---|
| <input type="checkbox"/> YES <input type="checkbox"/> NO Hepatitis Type _____ | <input type="checkbox"/> YES <input type="checkbox"/> NO Gastric Reflux/ GERD |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Jaundice | <input type="checkbox"/> YES <input type="checkbox"/> NO Drink Alcoholic Beverages, How much? _____ |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Frequent Heartburn | <input type="checkbox"/> YES <input type="checkbox"/> NO Kidney Disease |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Hiatal Hernia | <input type="checkbox"/> YES <input type="checkbox"/> NO Dialysis |

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PATIENT LABEL

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BLOOD SYSTEM

YES NO Bleeding Disorder Type_____

YES NO Blood Clots/ DVT

YES NO Sickle Cell Disease or Trait

Other:

YES NO Cancer? If yes, What kind and when?_____

YES NO Have a communicable disease such as TB, HIV, AIDS, Venereal Disease, Hepatitis etc.

YES NO Medi-port/ vein shunt/ port a cath/ Sub Q port etc.

YES NO Prosthetic or implant? Including breasts, joint replacements etc. Describe:_____

YES NO Body piercing or jewelry

YES NO Are you pregnant?

YES NO Dentures/ Partials/ Chipped or Loose teeth, Describe:_____

YES NO Other conditions being treated for?_____

YES NO Any concerns with your health?_____

YES NO Had any illness in the past month?_____

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

Walk across the room Walk one block Walk 1 mile Run 1 mile

If 1 block or less, what limits your activity?_____

YES NO Any other information you feel the anesthesiologist should know?_____

Medications: Please list the name of medications that you are taking *Include* Over the Counter medicines, chronic pain medications, herbs, vitamins, skin patches, eye drops, illegal drugs, oxygen, breathing treatment (nebulizer) medications. Please use additional sheet if needed.

Name of Medication	Dose	Frequency

YES NO **ALLERGIC TO LATEX**

LIST ALL ALLERGIES TO MEDICATIONS:

MEDICATION NAME	REACTION	MEDICATION NAME	REACTION
1.		5.	
2.		6.	
3.		7.	
4.		8.	

FORM COMPLETED BY:_____DATE_____RELATIONSHIP TO PATIENT_____

PATIENT NAME OR PERSON TO CONTACT_____

PHONE NUMBER(S) WHERE NURSE OR ANESTHESIOLOGIST MAY REACH YOU_____