Print Form

Date:_____ Time:_____ HT_____(in) WT_____(lb)
(REQUIRED) (REQUIRED)

1. GENERAL INFORMATION

Patient Name:_____ Date of Birth:_____

Name preferred to be called:_____ Form completed by:_____

Have you been hospitalized in the last 30 days?_____ If yes, when and where:_____

Emergency contact: (name)_____ Phone:_____

Describe reason for visit:_____

Who is your primary Doctor:(name)_____Date of last exam/tests:_____

	No	Yes	
2.	☐	☐	Are you allergic to **LATEX?**
3.	☐	☐	Do you have any objections to receiving blood products? If yes, describe_____
4.	☐	☐	Do you need an interpreter?_____Primary language spoken?_____
5.	☐	☐	Do you currently have a cough or night sweats which lasted over 2 weeks, bloody sputum, and/or a fever?
6.	☐	☐	Have you ever smoked? Packs/day_____Started:_____Stopped:_____
7.	☐	☐	Do you drink more than 10 alcoholic beverages per week?
8.	☐	☐	Have you had problems with drug/alcohol addiction or withdrawals?

Note: If you have taken illicit drugs and are having a procedure, please tell your surgeon and anesthesiologist, as it may affect your anesthesia and your reactions to medications.

9. Medical History (check if you have or have ever had any of the following): ☐ None

☐ Difficulty moving head or neck
☐ Difficulty opening your mouth
☐ Loose or chipped teeth
☐ Crowns, caps, veneers or dentures
☐ High blood pressure
☐ Chest pain/angina
☐ Congestive heart failure
☐ Heart attack (Date_____)
☐ Heart bypass (Date_____)
☐ Angioplasty or stent (Date_____)
☐ Pacemaker/AICD (Date_____)
☐ Heart murmur/heart valve problem
☐ Palpitations/irregular heart beat
☐ Asthma
☐ Bronchitis/emphysema
☐ COPD
☐ Sleep apnea
☐ Shortness of breath
☐ Recent flu or productive cough
☐ Diabetes (**See also question 10**)
☐ Kidney disease/dialysis
☐ Heartburn/acid reflux
☐ MRSA/VRE
☐ Hepatitis, cirrhosis, jaundice
☐ Epilepsy/seizures
☐ Stroke/loss of consciousness
☐ Prolonged numbness or paralysis
☐ Brain surgery/injury
☐ Rheumatoid arthritis
☐ Thyroid disease
☐ Blood disorder
☐ Anemia
☐ Blood clots
☐ Easy bruising/bleeding
☐ Incontinence (urine or stool)
☐ Joint stiffness
☐ Trouble walking
☐ Rash/itching
☐ Mental health issues
☐ Cancer (type)_____
☐ Chemotherapy/radiation therapy
☐ Contact lenses/hearing aids
☐ Prosthetic eye/limb
☐ Extreme weakness/fatigue
☐ Recent fever/chills
☐ Tuberculosis
☐ Vision problems
☐ Hearing problems

☐ Other (describe)_____

_____

_____

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PRE-ANESTHESIA QUESTIONNAIRE

PATIENT IDENTIFICATION

What is the most active thing you do on a regular basis? (How long/how often)_____

10. Please answer only if you have **DIABETES:**

No	Yes	
☐	☐	Do you use insulin?
☐	☐	Do you have an insulin pump?
☐	☐	Do you use oral diabetes medications?

What are your average fasting blood glucose levels?_____ What was your last HgbA1c?_____

11. CARDIAC/ANESTHESIA STATUS:

No	Yes	
☐	☐	Have you had heart tests such as ECG, echo cardiogram, cardio perfusion scan, stress test, cardiac catheterization, or angiography within the last five years?

List:_____ Where:_____

List:_____ Where:_____

List:_____ Where:_____

No	Yes	
☐	☐	Have you had problems with previous anesthetics? If yes, describe:_____
☐	☐	Have any of your blood relatives had unusual reactions to anesthetics?
☐	☐	Have you taken prednisone or steroids in the last 6 months?

12. PAST SURGERIES AND PROCEDURES: ☐ None

Date:	Procedure:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

13. WOMEN:

No	Yes	
☐	☐	Is there a possibility that you are pregnant? Date of last menstrual period:_____

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