ANESTHESIA QUESTIONNAIRE

Height _____ Weight _____

I. DRUGS AND MEDICATIONS:
List all medications you take, including dosage, including herbal supplements and vitamins _____

II. SURGERIES:
List all previous operations, year, and type of anesthesia. (gen., local, spinal)

Do you have any **MEDICATION ALLERGIES?** Yes No
If YES please list

Do you have any **FOOD ALLERGIES?** Yes No
If YES please list

Are you allergic to Latex: Yes No

List any other hospitalizations with reasons and approximate dates and any chronic illness(es) or condition(s):

Primary Care Physician _____
Phone: _____

III. HAVE YOU HAD:	PLEASE CIRCLE		(IF YES, PLEASE EXPLAIN)
1. High Blood Pressure	Yes	No	
2. Heart trouble or Heart Attack	Yes	No	
a) Chest pain or Angina	Yes	No	
b) Irregular Heart Beat	Yes	No	
c) Congestive Heart Failure	Yes	No	
d) Abnormal electrocardiogram	Yes	No	
3. Gastric Esophageal Reflux, Hiatal Hernia, Ulcers	Yes	No	
4. A recent cold, cough or sore throat	Yes	No	
5. Asthma. Emphysema, bronchitis	Yes	No	
or breathing problem	Yes	No	
6. Abnormal chest x-ray	Yes	No	
7. Diabetes	Yes	No	
8. Yellow jaundice/hepatitis/AIDS/HIV	Yes	No	
9. Kidney Disease or Thyroid Disease	Yes	No	
10. Abnormal bleeding problems	Yes	No	
11. Stroke, numbness or weakness	Yes	No	
12. Epilepsy or convulsive seizures	Yes	No	
13. Broken bones of back, neck or face	Yes	No	
14. Back trouble	Yes	No	
15. Unusual muscle problems or diseases	Yes	No	
16. Unexplained fevers or heatstrokes	Yes	No	
17. Bad reactions to anesthetics	Yes	No	
18. Any relative with bad reaction to anesthetics	Yes	No	
19. Psychological or emotional problems	Yes	No	
20. Any problems with motion sickness	Yes	No	
IV. DO YOU:			
1. Wear Dentures	Yes	No	
2. Have caps on teeth	Yes	No	
3. Drink alcohol (How much per day)	Yes	No	
4. Smoke (How much per day)	Yes	No	
5. Recreational Drug Use	Yes	No	
6. Exercise or have strenuous activity	Yes	No	
V. FEMALES: Last menstrual period _____			
VI. Are you aware there is a risk with EVERY Anesthetic given	Yes	No	

Anesthesia Pre-Op
For Anesthesiologist Use Only

PMH:

PSH:

Physical Exam:

Plan:

VI. Do you have questions or concerns you would like to discuss with your Anesthesiologist? _____

Anesthesiologist _____ **Date** _____ **Time:** _____

Signed by Patient _____ **Date** _____ **Time:** _____

PATIENT LABEL HERE