

ANESTHESIA PRE-OP QUESTIONNAIRE

PLEASE COMPLETE THIS FORM AND KEEP IT WITH YOU: Return clipboard to front desk.

Name: _____ Age: _____ Procedure: _____

List all previous operations you have had: _____

Any drug allergies:	N	Y		Have you or anyone in your family had Malignant Hyperthermia with anesthesia?	N	Y
Latex allergy:	N	Y		History of nausea after anesthesia?	N	Y
Do you smoke:	N	Y	Amt? _____	Any other problems with anesthesia?	N	Y
Do you drink alcohol:	N	Y	How Often? _____			

Do you have any of the following? Circle N or Y

Asthma	N	Y	_____	Irregular heartbeat or Arrythmia?	N	Y	_____
COPD	N	Y	_____	Recent chest pain	N	Y	_____
Recent Bronchitis	N	Y	_____	Mitral valve prolapse	N	Y	_____
Difficulty breathing?	N	Y	_____	High blood pressure	N	Y	_____
Diabetes?	N	Y	_____	Heart attack? Dates:	N	Y	_____
Kidney problems?	N	Y	_____	Congestive heart failure	N	Y	_____
Sleep Apnea?	N	Y	_____	Heart stents or angioplasty? Dates: _____	N	Y	_____
Thyroid disease?	N	Y	_____	Acid Reflux?	N	Y	_____
Sickle Cell disease?	N	Y	_____	Hepatitis/Liver dz.	N	Y	_____
Bleeding problems?	N	Y	_____	Peptic ulcer disease	N	Y	_____
Anemia?	N	Y	_____	Stroke?	N	Y	_____
Blood transfusion?	N	Y	_____	Seizure? Last one?	N	Y	_____
Arthritis?	N	Y	_____	Migraines?	N	Y	_____
Back pain?	N	Y	_____	Bipolar/Depression	N	Y	_____
Neck pain?	N	Y	_____	Do you have loose or chipped teeth?	N	Y	_____
History of cancer?	N	Y	_____	Do you have dentures?	N	Y	_____
				Do you have caps?	N	Y	_____

Have you ever had a heart catheterization to look for blockage in your heart?N Y

Have you been told you snore loudly? (can be heard in another room)N Y

Are you frequently sleepy during the day (more than normal) despite adequate sleep?N Y

Have you been told people notice you obstructing (your breathing) while sleeping?N Y

Any other medical conditions not mentioned above? _____