ANESTHESIA QUESTIONNAIRE

Patient Name:_____ Age: _____ Date of Surgery:_____

Type of Surgery: _____Surgeon: _____

I. DRUGS AND MEDICATIONS: (**Attach list on separate piece of paper if necessary**.)

List all medications including over the counter, herbal supplements and vitamins. Be sure to write dosage and when taken.

Medication Name:	**Dosage:**	**When Taken (Frequency):**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any **MEDICATION ALLERGIES**? YES NO If "YES" please list (include reaction): _____

_____

_____

_____

Do you have any **FOOD ALLERGIES**? YES NO If "YES" please list: _____

_____

Are you allergic to **LATEX or RUBBER PRODUCTS**? YES NO If "YES" list reaction:_____

_____

Have you been tested for latex/rubber sensitivity? YES NO

II. SURGERIES:

List all previous operations, year, and type of anesthesia (general, local, spinal):_____

_____

_____

_____

List hospitalizations other than surgeries with reasons and approximate dates: _____

_____

Primary Care Physician:_____ Phone: _____

Cardiologist: N/A ☐ or Name: _____ Phone: _____

Pulmonologist: N/A ☐ or Name: _____ Phone: _____

Other: N/A ☐ or Name: _____ Phone: _____

III. HEIGHT: _____ WEIGHT: _____

IV. DO YOU HAVE: PLEASE CIRCLE (IF YES, PLEASE EXPLAIN)

1. Snoring, gasping/snorting, frequent awakenings or restlessness while sleeping? Yes No _____
   - Daytime sleepiness? Yes No _____
   - Sleep apnea? Yes No _____
   - Do you use a CPAP? Yes No _____
2. High Blood Pressure Yes No _____

3.	Heart trouble or Heart Attack	Yes	No	_____
	a. Chest pain or Angina	Yes	No	_____
	b. Irregular Heart Beat, pacemaker, AICD	Yes	No	If yes, what type: _____
	c. Congestive Heart Failure	Yes	No	_____
	d. Abnormal electrocardiogram	Yes	No	_____
	e. Murmurs	Yes	No	_____
	f. Echo, stress test or cardiac catheterization	Yes	No	If yes, when/where/Dr. Name: _____
	g. Do you have a coronary stent?	Yes	No	If yes, when implanted/ what type: _____
4.	Gastric Esophageal Reflux, Hiatal Hernia, Ulcers	Yes	No	_____
5.	A recent cold, cough or sore throat	Yes	No	_____
6.	Asthma, emphysema, bronchitis, wheezing or breathing problems	Yes	No	_____
7.	Abnormal chest x-ray	Yes	No	_____
8.	Diabetes	Yes	No	_____
9.	Yellow jaundice or hepatitis	Yes	No	_____
10.	Kidney disease	Yes	No	_____
11.	Abnormal bleeding problems	Yes	No	_____
12.	Stroke, numbness or weakness	Yes	No	_____
13.	Epilepsy or seizures	Yes	No	_____
14.	Broken bones of back, neck or face	Yes	No	_____
15.	Back trouble, fusions or implants	Yes	No	_____
16.	Unusual muscle problems or diseases	Yes	No	_____
17.	Unexplained fevers or heatstrokes	Yes	No	_____
18.	Bad reactions to anesthetics	Yes	No	_____
19.	Any relative w/bad reaction to anesthetics	Yes	No	_____
20.	Psychological or emotional problems	Yes	No	_____
21.	Any problems with motion sickness	Yes	No	_____

V. DO YOU:

1.	Wear contacts	Yes	No	_____
2.	Wear dentures	Yes	No	_____
3.	Have any loose teeth or caps	Yes	No	_____
4.	Drink alcohol (how much per day)	Yes	No	_____
5.	Smoke (how much per day)	Yes	No	_____
6.	Use recreational drugs	Yes	No	_____
7.	Exercise or have strenuous activity	Yes	No	_____

VI. Females only: Can you be pregnant Yes No _____

VII. Are you aware there is a risk with **EVERY** Anesthetic given Yes No _____

VIII. If you have any questions or concerns please call the PAT nurse at (949) 452-7424

Phone number you can be reached at the evening before surgery: ( ) _____ - _____

Return this completed form **as soon as possible** for review by an anesthesiologist. **Please call Claudia Castillo to set up your pre-op appointment at 949-452-3129 and bring this form to your pre-op appointment.**

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ANESTHESIA QUESTIONNAIRE

ADDRESSOGRAPH (this space for office use only)