

# 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)

- 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 \_\_\_\_\_
- 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,<br>Hiatal Hernia, Ulcers              | Yes | No | _____                                    |
| 5. A recent cold, cough or sore throat                              | Yes | No | _____                                    |
| 6. Asthma, emphysema, bronchitis,<br>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-appointment at 949-452-3129 and bring this form to your pre-appointment.**