PRE-ANESTHETIC PATIENT QUESTIONNAIRE

Once in Hospital:
PLACE PATIENT ID LABEL HERE

Patient Name: _____

Height: _____ **Weight:** _____ ☐ **lb** / ☐ **kg**

Form Completed By: _____ **Date Completed:** _____

	Please check 'yes' or 'no' if you have history of the following:	YES	NO	Explain
ANESTHESIA/SURGERY	Have you ever had anesthesia? ☐ Spinal/Epidural ☐ General			
	Surgeries and dates:			
	Have you ever had problems with anesthesia? (Difficulty with insertion of a breathing tube, breathing problems, nausea)			
	Has anyone in your family ever had problems with anesthesia?			
	Do you or any of your relatives have: ☐ Malignant Hyperthermia ☐ Pseudocholinesterase Deficiency			
	Are any of your teeth: ☐ Loose ☐ Broken/Chipped ☐ Capped			
	Do you have Dentures? Upper: ☐ Full ☐ Partial; Lower: ☐ Full ☐ Partial			
RESPIRATORY	Have you had a cold, flu, or chest infection in the last month?			
	Shortness of Breath with: ☐ Normal Activity ☐ At rest			
	Lung Disease: ☐ Asthma ☐ Emphysema ☐ COPD ☐ Pulmonary Hypertension			
	☐ Puffers for your breathing ☐ Home oxygen			
	Sleep apnea, loud snoring, or breathing pauses while snoring If yes, is your sleep apnea treated with CPAP? ☐ Yes ☐ No			
	Do you have a Respirologist? Name:			
CARDIOVASCULAR	☐ High blood pressure ☐ High cholesterol			
	Chest Pain: ☐ Angina ☐ Heart attack When:			
	☐ Stents ☐ Cardiac surgery If yes, please explain:			
	☐ Heart valve problems or ☐ Valve Replacement			
	An irregular heartbeat (Dysrhythmia)			
	☐ Pacemaker ☐Defibrillator (ICD) Last checked:			
	Congestive Heart failure (CHF)			
	Peripheral Vascular Disease (problems with circulation in legs)			
	☐ Stroke ☐ TIA (mini-stroke) When:			
	Do you have trouble walking 2 blocks without stopping or climb a flight of stairs?			
	Do you have a Cardiologist? Name:			
RENAL/ GI	Kidney disease Dialysis: ☐ Peritoneal ☐ Hemodialysis			
	☐ Heart burn ☐ Acid Reflux ☐ Ulcers			
	Liver Disease: ☐ Cirrhosis ☐ Hepatitis			
	☐ Crohn's Disease ☐ Ulcerative Colitis			

Patient Name: _____ **Hospital #:** _____

	Please check 'yes' or 'no' if you have history of the following:	YES	NO	Explain
ENDOCRINE	Diabetes: ☐ Type 1 ☐ Type 2 How long: Managed with ☐ Diet ☐ Pills ☐ Insulin			
	Thyroid problems			
	Steroid use in the past year (e.g., prednisone, decadron, etc.)			
NEURO/MSK	Seizures / Epilepsy When was your last seizure:			
	Arthritis: ☐ Osteoarthritis ☐ Rheumatoid Arthritis			
	Other neurologic or muscular disorders:			
HEMATOLOGIC	Anemia (low blood count)			
	Bleeding disorder(s):			
	Blood clots in the ☐ Legs (DVT) or ☐ Lungs (Pulmonary Embolism)			
	Blood thinners in the last month? Type:			
	Previous blood transfusion? When:			
OTHER SYSTEMS	Cancer Type: Treatment:			
	☐ Depression ☐ Anxiety ☐ Bipolar ☐ Schizophrenia			
	☐ Chronic Pain ☐ Fibromyalgia			
	☐ Cognitive Disability ☐ Physical Disability			
	Is there a chance you might be pregnant?			
	Any other medical problem not listed above?			
SOCIAL HISTORY	Do you smoke cigarettes/vape or have you ever smoked/vaped? For how many years: How much: If you used to smoke/vape, when did you quit:			
	Do you drink alcohol? How many drinks per week:			
	Do you smoke or use marijuana? How much: How often:			
	Do you use any recreational or street drugs?			

Allergies ☐ No Allergies

Are you allergic to latex? ☐ Yes ☐ No Are you allergic to nickel? ☐ Yes ☐ No

Allergy/ Adverse Reaction	Type of Reaction	Allergy/ Adverse Reaction	Type of Reaction
1.		**4.**	
2.		**5.**	
3.		**6.**	

Medications (including puffers, insulin, and injections) ☐ No Medications

Medication Name	Dose	Medication Name	Dose