Coast Surgery Center

PRE-ANESTHESIA SURGERY QUESTIONNAIRE

The answers to the following questions help your anesthesiologist provide the safest & most individually appropriate anesthesia for *you*. Please check *only* **YES, NO, or ?.** If you select YES or ?, the anesthesiologist will document your explanation.

PATIENT CHECK LIST

Yes	No	?	**Age_______ Height ________ Weight _________ lbs.**
☐	☐	☐	1. Have you had SURGERY before?
☐	☐	☐	2. Any **problems with ANESTHESIA**? *(i.e., nausea, vomiting, dizziness, headaches, low blood pressure)*
☐	☐	☐	3. Has any ***blood relative*** had a problem with Anesthesia?
☐	☐	☐	4. Have you ever had ***motion sickness***?
☐	☐	☐	5. Do you have any loose teeth, dentures, bridges, or limitation opening mouth?
☐	☐	☐	6. Have you ever had an ALLERGIC REACTION to any medication, foods or **latex**? If yes, what were they? ____________________
☐	☐	☐	7. **Your family physician's NAME** ____________________ **Your family physician's PHONE #** (______) ____________
			8. Do you have any **MEDICAL PROBLEMS**? *(Circle)*
☐	☐	☐	CARD-Coronary Artery Disease, Angina, Palpitations, Murmurs, Hypertension
☐	☐	☐	PULMONARY - Asthma, Bronchitis, Emphysema, Hay Fever
☐	☐	☐	LIVER - Hepatitis, Jaundice, Blood Transfusion reaction
☐	☐	☐	KIDNEY - Renal Stones, Bladder Infections
☐	☐	☐	ENDOCRINE - Diabetes, Hypoglycemia, Thyroid Disease, Other
☐	☐	☐	NEUROLOGY- Fainting Spells, Seizures, Convulsions, Migraines
☐	☐	☐	MUSCULO-SKELETAL - Disc Disease, Back/Neck Pain, Arthritis, Bursitis
☐	☐	☐	GASTRO-INTESTINAL -Ulcers, Gastritis, Reflux, Hiatal Hernia, Obesity
☐	☐	☐	9. Do you Smoke? If yes, how much? ____________________
☐	☐	☐	10. Have you ever had an **abnormal** EKG, chest x-ray, or blood test?
☐	☐	☐	11. Have you had any Serious Illnesses requiring Hospitalization? If Yes, explain: ____________________
☐	☐	☐	12. Do you have any other Medical Condition? ____________________
☐	☐	☐	13. Have you had a cold in the past 2 weeks? If yes, what were the symptoms? *(fever, chills, sore throat,____________________)*
☐	☐	☐	14. Within the last 2 weeks, have you been exposed to any communicable diseases? *(i.e., chicken pox, mumps, measles /rubeola, or German measles/rubella)*
☐	☐	☐	15. Are you pregnant at this time?
☐	☐	☐	16. Are you trying to get pregnant at this time?
☐	☐	☐	17. Do you take MAOI, Fen/Phen, or St.John's Wort? If Yes, you **must** discontinue use at least 2 weeks prior to surgery.

ADDITIONAL HX BY ANESTHESIOLOGIST

____

Physical Exam:

HEENT:

Chest:

Cardiac:

Other:

ASA: I II III

Plan:

Anesthesia risks, indications, alternative and plan have been discussed with patient & patient agrees.

Anes. Sig. ______________________________MD

Date: ____________________ Time: __________

CONSENT:____ ____________________

Signature of patient (or legal guardian of patient) consenting for anesthesia *Date*

[Place Patient Label Here]