ANESTHESIA QUESTIONNAIRE

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Sex: _____

Drug Allergies: **Please bring a complete list of drug allergies and reactions.**

_____

Medications: **Please bring complete list of medications, along with name, dose, and frequency.**

_____

Height: _____ Weight: _____

HISTORY: ***Please check Yes or No for each question***

Diabetes	□ Yes □ No	Chronic Cough	□ Yes □ No	Stroke	□ Yes □ No
Heart Problems	□ Yes □ No	Dizziness	□ Yes □ No	Seizures	□ Yes □ No
High Blood Pressure	□ Yes □ No	Mental Illness	□ Yes □ No	Hepatitis	□ Yes □ No
Irregular Heartbeat	□ Yes □ No	Kidney Problems	□ Yes □ No	Liver Disorder	□ Yes □ No
Chest pains/Angina	□ Yes □ No	Back problems	□ Yes □ No	Blood Transfusion	□ Yes □ No
Heart surgery	□ Yes □ No	Arthritis	□ Yes □ No	Drink alcohol	□ Yes □ No
Pacemaker	□ Yes □ No	Smoke _____ Pks. Day	□ Yes □ No	Bronchitis	□ Yes □ No
Shortness of breath	□ Yes □ No	Emphysema	□ Yes □ No	HIV/Aids	□ Yes □ No
Asthma	□ Yes □ No	Prolonged bleeding	□ Yes □ No	High temperature	□ Yes □ No
Positive T.B. test	□ Yes □ No	Blood in sputum	□ Yes □ No	Weight loss	□ Yes □ No
Night sweats	□ Yes □ No				

Type of surgery and approximate date: _____

Other medical conditions: _____

Name of the doctor you see for regular health care: _____

Previous problems with anesthesia (you): □ Yes □ No

Previous problems with anesthesia (family members): □ Yes □ No

I HAVE REVIEWED THE ABOVE INFORMATION

Patient signature	Physician signature	Date

Information will be protected under HIPAA