



Pre-Anesthetic Questionnaire:

DATE: \_\_\_\_\_

Empty box for patient information

“CHIEF COMPLAINT”: \_\_\_\_\_ CELL PHONE#: \_\_\_\_\_

PROPOSED OPERATION: \_\_\_\_\_ HT: \_\_\_\_\_ WT: \_\_\_\_\_

\*\*List ALL Drug or Food Allergies, including Latex: \_\_\_\_\_

ARE YOU A PREVIOUS LAP BAND/ GASTRIC BYPASS PATIENT?: YES \_\_\_ NO \_\_\_ Date of onset of symptoms: \_\_\_\_\_

PAST MEDICAL/SURGICAL HISTORY

Table with columns for Primary Care Physician, Cardiologist, and Previous Operations/Procedure/Date (1-8)

Approximate date of last Anesthetic/Surgery: \_\_\_\_\_ Anesthesia Comments: \_\_\_\_\_
Have you had any problems with anesthesia? NO \_\_\_ YES \_\_\_
Have any blood relatives had a serious problem with anesthesia? NO \_\_\_ YES \_\_\_
Have you taken steroids (Cortisone, Prednisone, Hydrocortisone, or Decadron) within the past 12 months? NO \_\_\_ YES \_\_\_

REVIEW OF SYSTEMS: Do YOU HAVE A HISTORY OF THE FOLLOWING MEDICAL PROBLEMS?

Grid of medical conditions with NO/YES columns: Any Heart Studies, High Blood Pressure, Chest Pain, Heart Attack, Heart Murmur, Heart Disease, Elevated Cholesterol, Varicose Veins, Prevalent DVT, Asthma, Limited Neck Motion, Jaw Clicking, Hepatitis, Facial Plastic, Nausea, Indigestion, Ulcerative Colitis, Previous colonoscopy, Kidney Disease, Diabetes, Fasting Blood Sugar, Anemia, Sickle Cell, Epilepsy, Fainting, Stroke, Depression, Back Problems, Thyroid Problems, Eye Diseases, Recent Cough, Headaches, Cancer, Breathing difficulties, Sleep Apnea, Family History of Heart Disease.

Other:

Do you frequently awaken with numbness in an arm or leg? NO \_\_\_ YES \_\_\_
Are you Pregnant? NO \_\_\_ YES \_\_\_ Not Sure \_\_\_ Not Applicable \_\_\_ Date of last menstrual period \_\_\_\_\_
Are you Right handed? \_\_\_ Left handed? \_\_\_
Do you wear contact lenses? NO \_\_\_ YES \_\_\_ NOTE: If yes, please remove them before surgery.
Do you have Capped Teeth / Crowns \_\_\_ Loose Teeth \_\_\_ Bridges \_\_\_ Dentures/Partials \_\_\_
Do you have Advance Directives/ Living Will? NO \_\_\_ YES \_\_\_ (If YES, please have patient bring copy, if possible)

SOCIAL HISTORY

Occupation: \_\_\_\_\_ What type of exercise do you get? \_\_\_\_\_
Do/Did you smoke? NO \_\_\_ YES \_\_\_ Packs Per Day \_\_\_ How many Years? \_\_\_ Quit when? \_\_\_\_\_
What is your alcohol consumption? \_\_\_\_\_
Do/Did you have a problem with drug or alcohol dependence/addiction? \_\_\_\_\_
Do you have a religious objection to blood transfusion? NO \_\_\_ YES \_\_\_

PATIENT SIGNATURE \_\_\_\_\_

VERIFIED BY: \_\_\_\_\_ RN TIME: \_\_\_\_\_

NO \_\_\_ YES \_\_\_ DISCLOSURE ALERT