ADULT PRE-OPERATIVE ANESTHESIA QUESTIONNAIRE

PATIENT'S NAME:_____ DATE:_____

QUESTION	YES	NO	COMMENTS
Height:_____ (cm) Weight:_____ (kg)			
Current Medications, Including Over-the-Counter & Herbal (dose & frequency):			
Allergies (include drugs, foods, & environmental items, i.e., latex):			
Previous Surgeries/Hospitalizations (list):			
Scheduled Surgery/Procedure:			
Anesthesia History			
Problems with anesthesia – self or blood relative?			
Respiratory			
Lung or breathing problems?			
Cough? If yes, do you bring up anything when you cough?			
Asthma? If yes, what is current treatment?			
Cold, flu, respiratory infection within the past 6 weeks?			
Diagnosed with sleep apnea? Do you snore?			
Ever required supplemental oxygen therapy?			
Abnormal chest x-ray?			
Smoke now or in past? If so, what type, how much, and for how many years?			
Exposed to passive smoke?			
Can you walk up two flights of stairs without getting short of breath?			
Do you have trouble walking one block?			
Cardiovascular			
Short of breath at night?			
Heart murmur?			
Heart attack, angina (with activity; @ rest), or chest pain related to your heart?			
Irregular heartbeat, or pacemaker?			
Congestive heart failure?			
Abnormal electrocardiogram?			
Problems with high blood pressure?			
Renal			
Kidney, bladder, or urine problems?			
Hepatic			
Jaundiced, now or in past?			
Liver problems, i.e., hepatitis?			
Use alcohol? If so, how much, how often, and when did you last use alcohol?			
Gastrointestinal			
Acid reflux, hiatal hernia, ulcer, or heartburn?			
Recent diarrhea?			
Neurologic			
Stroke, seizures, episodes of unconsciousness or fainting, or other neurological problems?			

QUESTION	YES	NO	COMMENTS
Numbness or weakness in an arm or leg?			
Frequent headaches?			
Eye problem or problems with your vision?			
Hearing problems?			
Endocrine			
Diabetes or high blood sugar?			
Thyroid problems?			
Steroids (i.e. prednisone) during the past year?			
Musculoskeletal			
Back or neck problems?			
Arthritis?			
Physical disabilities?			
Hematologic			
Bleed easily?			
Anticoagulants (blood thinners) within the past month?			
Ever been anemic?			
Evaluated for sickle cell anemia?			
Object to blood products under any circumstances?			
Cancer			
Diagnosed with cancer?			
Received treatment for cancer?			
Obstetrical			
Could you be pregnant? If yes, how many weeks?			
Airway			
Chipped or loose teeth, dentures, caps, bridgework?			
Problems with opening your mouth? Temporomandibular joint (TMJ) problems?			
Difficult airway management with previous anesthesia?			
Psychosocial			
Ever had mental health treatment?			
Taken prescribed psychiatric medications?			
Used "street" or "recreational" drugs? If so, when did you last use?			
Birth & Developmental (pediatrics)			
Child's delivery premature or at term?			
Neonatal complications?			
History of low heart rate or periods of low or absent respirations?			
Sudden infant death syndrome (SIDS) in your family?			
Do you have any medical problems that have not been discussed?			

IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT YOUR HEALTH?

SIGNATURE:_____ DATE:_____

REVIEWED BY:_____ DATE:_____