



Pre-Anesthesia Patient Questionnaire

Patient's Name: _____

Date: _____

Please answer the following questions so that we can provide the anesthetic that is best for you. The Anesthetist providing your care will be happy to assist you and provide you with information about the risks and benefits of the proposed anesthetic.

Body Weight: _____ Body Height: _____

Previous Operations/Dates:

Drug Allergies: _____

Current Medications:

Please Circle YES or NO for each question: (ALL questions Must be answered)

Do you have heart troubles? YES NO
 Explain _____

Do you take heart or blood pressure medications? YES NO

Do you get pains in your chest when you exercise? YES NO

Do you get pains in your chest when you rest? YES NO

Do you have troubles breathing? YES NO

Do you have bronchitis or a chronic cough? YES NO

Do you feel short of breath at times? YES NO

Is it difficult for you to climb stairs? YES NO

Do you or did you smoke? YES NO

If yes, packs per day _____ # of years

Do you drink alcohol on a regular basis? YES NO
 How much/how often _____

Do you have diabetes? YES NO
Insulin: _____ Other meds: _____

Have you had Hepatitis, liver disease, or yellow jaundice? YES NO
When _____

Have you had Kidney disease? YES NO

Do you have ulcers or stomach problems? YES NO
Explain _____

Do you have a hiatal hernia? YES NO

Do you have constant back or neck pain? YES NO

Do you have any limb paralysis, numbness or weakness? YES NO
Explain: _____

Do you have any muscle or nerve diseases? YES NO

Do you have arthritis? YES NO
Where? _____

Do you ever have trouble with any anesthesia in the past? YES NO
Explain: _____

Have any of your blood relatives had problems with anesthesia in the past? YES NO
Explain? _____

Do you have any bleeding problems? YES NO

Have you had a blood transfusion? YES NO

Do you have loose, chipped, false teeth, or bridgework? YES NO

Have you taken cortisone in the past 6 months? YES NO

Do you get claustrophobia? YES NO

Do you have thyroid problems? YES NO

Patient Signature _____ **Date** _____

Doctor's Signature _____ **Date** _____

Anesthesia's Signature _____ **Date** _____