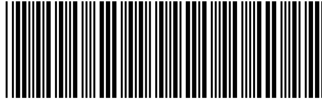
Form ID - SRG.ANESQU



CLARA BARTON
Hospital
250 West Ninth
Hoisington, Kansas 67544

Acct No. -

Patient Name: ___________________________ MR#:____________ Date: _____________

DEPARTMENT OF ANESTHESIOLOGY PRE-OPERATIVE ANESTHESIA QUESTIONNAIRE

I. PERSONAL PROFILE

Please print

Name___________________ Occupation________________

Age______ Height _______ Weight _______ Retired ______

Physical Activity: Limited ❑ Moderate ❑ Active ❑

What activities do you participate in? __________________

____

Date of Last Physical Exam __________________________

Chest x-ray ________________

EKG ______________________

II. FAMILY HISTORY

Do **YOU** or **ANY BLOOD RELATIVES** have:

YES NO

❑ ❑ Bleeding problems

❑ ❑ High fevers during or after surgery

❑ ❑ Severe reactions/death caused by anesthetics

Please check **YES** or **NO** and Circle all Applicable Itmes.

YES NO Are you allergic to any medications or food?

❑ ❑ If yes, list _______________________________

❑ ❑ Have you ever smoked cigarettes, cigars or pipes?
How many ______ packs per day?
How many ______ years?

❑ ❑ Do you drink alcohol beverages more than 3 times weekly? Beer, Wine, 80+ Proof:
How much __________ How often __________

❑ ❑ If Female, is there any possibility you are currently pregnant?

❑ ❑ Are you breast feeding?

❑ ❑ Do you wear dentures, braces, bridges, porcelain caps or other dental appliances?

❑ ❑ Do you have false eyelashes, contact lenses, false nails?

❑ ❑ Have you ever taken any illicit drugs by any route of administration?
Please list _______________________________
____

❑ ❑ Do you have loose, missing or damaged teeth? Temporary fillings?

❑ ❑ Do you have any difficulty fully opening your mouth or bending your neck?

❑ ❑ Are you affected by motion sickness?

Anesthesia care is becoming increasingly safe, but it should be understood that, like any medical procedure, there are certain risks that are associated with administration of all types of anesthetics. Although major complications are very rare, death and major disability are always possible. Please sign below when you have completed this form and are satisfied that you understand its contents.

____
Patient/Responsible party

____
Relationship

____
Date

III. PAST HISTORY

Have you ever had any of the following conditions? If yes, please Circle and give dates.

Heart Disease, Heart Attack, High Blood Pressure, Rheumatic Fever, Heart Murmur, Irregular, fast or slow heartbeat ______
____

Lung disease, Emphysema, Asthma, TB Chronic Bronchitis, Pneumonia, Shortness of Breath______________________
____

Diabetes, Thyroid Disease, Kidney Disease, Adrenal Gland problems ______________________________________

Liver Disease, Hepatitis, Cirrhosis, Jaundice _____________
____

Ulcers, Hiatus Hernia, Intestinal Obstruction ______________
____

Strokes, Seizures, Fainting Episodes, Paralysis, Psychiatric problems, Depression, Anxiety

Reactions ______________________________________
____

Neck or Back Injuries, Low Back Pain, Neck/Spine Arthritis
____

Glaucoma, Cataracts, Eye Prosthesis, Hearing Disability ___
____

Blood Transfusion Reaction, Anemia, Sickle Cell Disease ___
____

Phlebitis, Blood Clots, Muscle Disease or Weakness ______
____

IV. SURGICAL HISTORY

Please list ALL previous operations you have had.

Type of Surgery	Year	Type of Anesthesia	Complications (if any)

V. MEDICATION SUMMARY

Please list ALL drugs you are currently taking including aspirin, and cold preparations, sleep meds, eye meds, tranquilizers, antidepressants, blood thinners, water pills heart meds, cortisone or other steroids.

Medication	Dosage	Times Per Day