Chardon Surgery Center

Pre-Anesthesia Questionnaire

The information you supply below assists in the development of your anesthesia care.
Please complete this questionnaire accurately and completely.

Name: _____ ☐ Male ☐ Female DOB: _____ Age: _____

Date of Surgery: _____ Height: _____ Weight: _____

Home Phone #: _____ Cell Phone #: _____

Primary Physician: _____ Phone #: _____

Cardiologist: _____ Phone #: _____

Other Physician/Specialist: _____ Phone #: _____

Medication List *Please list all medications you are taking.*		

Health History			
Please answer the following questions:	Yes	No	If yes, please explain.
Have you taken prednisone or other steroids in the past 3 months?			
Do you have a latex allergy?			
Do you have allergies to medications or food? If yes, please list and describe your reaction.			
Have you ever had a problem with anesthesia including malignant hyperthermia or a difficult intubation? If yes, please describe.			
Has any family member had a problem with anesthesia? If yes, please describe.			
Do you have any loose, capped or broken teeth? Bridges or dentures?			
Do you have trouble opening your mouth or with your jaw clicking?			
Do you have shortness of breath or chest discomfort after walking up one flight of stairs?			
Do you use home oxygen?			
Do you smoke?			How much? How long?
Are you an ex-smoker?			When did you stop?
Do you drink alcoholic beverages?			How many per week?
Have you used street drugs in the last 6 months?			When did you last use?

Health Conditions	*Check all that apply.*		
Cardiac ☐ Abnormal EKG ☐ Atrial fibrillation ☐ Congestive heart failure ☐ Heart disease ☐ Heart attack ☐ High cholesterol ☐ Hypertension ☐ Pacemaker/ICD – bring implant card with you	**Bleeding Circulation** ☐ Anemia ☐ Bleeding tendency ☐ Blood clots ☐ Poor circulation ☐ Sickle cell	**Respiratory** ☐ Asthma ☐ Bronchitis ☐ Difficulty breathing ☐ Emphysema ☐ Hoarseness ☐ Pneumonia ☐ Sleep apnea ☐ Smoker ☐ TB	**Gastrointestinal** ☐ Recurrent gastric reflux ☐ Hernia ☐ Ulcers ☐ Diverticular disease ☐ Colitis/Crohn's disease ☐ Difficulty swallowing ☐ Irritable bowel syndrome
Endocrine ☐ Diabetes ☐ Liver disease ☐ Thyroid problems/goiter ☐ Adrenal disease	**Genitourinary** ☐ Kidney disease ☐ Kidney stones ☐ Prostate problem ☐ Urinary tract infection ☐ Dialysis	**Skin** ☐ Rashes ☐ Sore/open areas	**Musculoskeletal** ☐ Arthritis ☐ Limited movement ☐ Multiple sclerosis ☐ Muscular dystrophy
Neurological/Mental Health ☐ Stroke ☐ Mini Stroke (TIA) ☐ Seizures ☐ Migraine headaches ☐ Alcoholism ☐ Chemical dependency ☐ Myasthenia gravis ☐ Depression/Anxiety	**Infectious Diseases** ☐ C-Dif ☐ Hepatitis ☐ HIV ☐ MRSA ☐ Recent mononucleosis (i.e. mono)	**Implantable Devices** ☐ Ports/Pumps ☐ Other – please list: **Important! Please bring implant card with you.**	**Cancer or Tumor** ☐ None ☐ Type_____ ☐ Chemo_____ ☐ Radiation_____ ☐ Oncologist_____
If you have been hospitalized for any of the conditions listed above please provide additional details.			

Surgical History	*Check all that apply.*		
☐ No prior surgery ☐ Appendectomy ☐ Angioplasty/Stent ☐ Arthroscopy ☐ Breast biopsy ☐ Cataract ☐ Cardiac bypass/CABG ☐ Gallbladder	☐ D&C ☐ Heart valve replacement ☐ Hemorrhoidectomy ☐ Hernia ☐ Hysterectomy ☐ Implanted defibrillator ☐ Kidney removal ☐ Mastectomy	☐ Pacemaker ☐ Prostate ☐ Splenectomy ☐ Spine (back/neck) ☐ Tonsils & adenoids ☐ Total knee (L/R) ☐ Total hip (L/R) ☐ Tubal ligation	☐ Other – please list:

Patient Signature: _____ Date: _____

If not completed by the patient please provide the following information:

Completed by: _____ Relationship to Patient: _____ Date: _____