[PT LABEL]

ANESTHESIA PREOPERATIVE QUESTIONNAIRE

Please check the appropriate boxes below

YES	NO	Have you ever had/ Do you have?
[ ]	[ ]	Angioplasty/ Coronary Stents
[ ]	[ ]	Arthritis
[ ]	[ ]	Asthma
[ ]	[ ]	Back or Neck Injuries
[ ]	[ ]	Anemia or Bleeding Tendencies
[ ]	[ ]	Cancer
[ ]	[ ]	Chest Pain (Angina)
[ ]	[ ]	Congestive Heart Failure
[ ]	[ ]	COPD/ Emphysema/ Lung Disease
[ ]	[ ]	Sleep Apnea/ CPAP
[ ]	[ ]	Diabetes
[ ]	[ ]	GI Disorder/ Ulcers/ Hiatal Hernia/ Reflux
[ ]	[ ]	Glaucoma
[ ]	[ ]	Heart Attack/ MI
[ ]	[ ]	Previous Heart Surgery
[ ]	[ ]	High Blood Pressure
[ ]	[ ]	High Cholesterol
[ ]	[ ]	Peripheral Vascular Disease
[ ]	[ ]	Aneurysm of: Head/ Abdomen
[ ]	[ ]	Infectious Disease/ HIV
[ ]	[ ]	Irregular/ Fast Heartbeats
[ ]	[ ]	Jaundice/ Hepatitis
[ ]	[ ]	Kidney Disease
[ ]	[ ]	Lens Implants/ Contact Lenses
[ ]	[ ]	Loose/ Cracked/ Chipped Teeth
[ ]	[ ]	Dentures or Caps
[ ]	[ ]	Mental Illness/ Depression
[ ]	[ ]	Pacemaker/ Internal Defibrillator
[ ]	[ ]	Paralysis or Numbness
[ ]	[ ]	Phlebitis
[ ]	[ ]	Pneumonia
[ ]	[ ]	Seizures/ Epilepsy
[ ]	[ ]	Shortness of Breath
[ ]	[ ]	Stroke/ TIA
[ ]	[ ]	Thyroid Disease
[ ]	[ ]	Tuberculosis
[ ]	[ ]	Vertigo /Syncope/ Motion Sickness

Other Medical Problems: _____

_____

_____

_____

_____

YES	NO	Do You?
[ ]	[ ]	Smoke? (Packs/ Day) _____ Quit Smoking _____ Years Ago Never Smoked [ ]
[ ]	[ ]	Use Alcoholic Beverages Occasional [ ] _____Drinks/ Day
[ ]	[ ]	Use Recreational Drugs
[ ]	[ ]	Cocaine Use in Past 72 Hours
[ ]	[ ]	Object to Blood Transfusion if Needed to Save Your Life
[ ]	[ ]	Have Any Body Piercings

If Female of Child Bearing Age:

[ ] [ ] Is There ANY Possibility You Could Be Pregnant?

Date of Last Menstrual Cycle: _____

Previous Anesthetic History:

Date of Last Anesthetic or Sedation: _____

[ ] [ ] Any Abnormal Reactions

[ ] [ ] Any Relatives with Abnormal Reactions to Anesthetics (i.e. Fever?)

[ ] [ ] Have Any Problems to Discuss with the Anesthesiologist?

Comments about Previous Anesthetics

_____

_____

_____

_____

List Previous Surgeries with Dates

_____

_____

_____

_____

_____

_____

_____

List Previous Heart/ Vascular Procedures with Dates

_____

_____

_____

_____

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_____

List Allergies and Type of Reaction

_____

_____

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_____

_____

_____

_____

List Medications You Are Presently Taking on Page 2 (Prescription and over-the-counter medications or herbal preparations)

Form Completed By: _____ **Date:** _____

PATIENTS & FAMILIES DO NOT WRITE BELOW THIS LINE PATIENTS & FAMILIES DO NOT WRITE BELOW THIS LINE

Complete Prior to Each Procedure

Surgical Scrub Night Before Surgery YES NO

Surgical Scrub This Morning YES NO

T _____ BP _____/_____ P _____ R _____ SaO2 _____%

Time of Last Food or Drink _____

Height _____ Weight _____ BMI _____

RN Signature: _____ Date: _____ Time: _____

↓ FOR PHYSICIAN USE ↓

[ ] I have discussed risks and benefits of anesthesia/ moderate sedation with patient. Informed consent given

[ ] Patient is an appropriate candidate for planned anesthesia/sedation

[ ] Patient seen and examined

Exam: Airway WNL Other _____

Heart WNL Other _____

Lungs WNL Other _____

[ ] Anesthesia & medication history reviewed with patient/family

[ ] H&P Unchanged

H&P Changes: _____

_____

Airway-Mallampati Score (Anesthesiologist)

[ ] Class 1: Complete visualization of the soft palate

[ ] Class 2: Complete Visualization of the uvula

[ ] Class 3: Visualization of only the base of the tongue

[ ] Class 4: Soft Palate is not visible at all

Physician Plan: _____

_____

_____

Anesthetic Proposed:

[ ] General [ ] Local standby/MAC

[ ] Spinal [ ] Regional

[ ] Moderate Sedation

ASA Status 1 2 3 4 5 6 Emergency

Physician Signature: _____

Date: _____ Time: _____