THE ANESTHESIA GROUP OF SARASOTA, P.A.

PRE-ANESTHESIA QUESTIONNAIRE

Name:______________________________ Age:__________ Ht:__________ Wt: __________

Home Telephone:______________________________ Other Telephone: ______________________________

Family Doctor/Phone #:______________________________ Who lives at home with you? ____________________

Do you have transportation available to you? ______________________________

List all medications (including over-the-counter) you currently take. Include dosage and frequency (how much and how often).

____

____

____

____

Are you allergic to anything? If yes, what?

____

____

List all operations you have had (operation/date): ______________________________

____

____

____

____

Please answer the following questions listed below:	**Yes**	**No**	**Comments**
Have you had any serious or life-threatening illnesses in the past?	☐	☐	____________
Have you or a family member had problems with anesthesia, other than nausea or vomiting?	☐	☐	____________
Have you had asthma or other problems with your breathing?	☐	☐	____________
Have you had any problems with your heart or circulation, blood pressure?	☐	☐	____________
Have you had chest pressure, pain, or severe shortness of breath with exertion?	☐	☐	____________
Have you had diabetes/high blood sugar?	☐	☐	____________
Have you had ulcers, a hiatal hernia, or frequent heartburn?	☐	☐	____________
Have you had seizure disorder, stroke, or other neurological problems?	☐	☐	____________
Do you bleed easily? Frequently take aspirin or aspirin-like medications?	☐	☐	____________
Are you more than 50 pounds overweight?	☐	☐	____________
(If applicable) Could you be pregnant?	☐	☐	____________
Have you had a history of TB disease or recent exposure to active TB?	☐	☐	____________
Have you experienced any of the following symptoms: bloody sputum, night sweats, fever, weight or appetite loss, or persistent cough for more than three weeks?	☐	☐	____________

Check the box ONLY if your answer isYES to the questions listed below. Do you currently have, or have you ever had:

- ☐ An abnormal chest x-ray? ______
- ☐ Wake up short of breath? ______
- ☐ A heart defect/murmur? ______
- ☐ Rheumatic fever? ______
- ☐ Kidney problems? ______
- ☐ Thyroid problems? ______
- ☐ Arthritis? ______
- ☐ Jaundice? ______
- ☐ Other? ______
- ☐ Hepatitis? ______
- ☐ Anemia or "low blood count"? ______
- ☐ Blood transfusion reaction? ______
- ☐ Passed out? ______
- ☐ Frequent headaches? ______
- ☐ Persistent back pain? ______
- ☐ Stiffness in neck or jaw? ______
- ☐ Physical disabilities? ______
- ☐ Hearing impaired? ______

Alcohol use
- ☐ None
- ☐ Occasional
- ☐ Daily

Type: ______

Amount: ______

Tobacco use
- ☐ None
- ☐ Ex-smoker

Date stopped ______
- ☐ Smokes

Amount/Day: ______

For how many years: ______

Recreational drug use
- ☐ None
- ☐ Occasional
- ☐ Daily

Type: ______

Use of Diet pills - IMPORTANT
- ☐ None
- ☐ Occasional
- ☐ Daily

Type: ______

Please check any of the following you currently have or use:

- ☐ Upper dentures ☐ full or ☐ partial
- ☐ Lower dentures ☐ full or ☐ partial
- ☐ Loose teeth, chipped teeth
- ☐ Capped teeth or bridgework
- ☐ Braces
- ☐ Glasses or contact lenses
- ☐ Hearing aid ☐ right and/or ☐ left
- ☐ Prosthesis/implant, where? ______

Last time you had LAB TESTS ?
- ☐ None
- ☐ Blood Count ______
- ☐ EKG ______
- ☐ Other: ______

Where: ______

Person Completing Questionnaire ______ **Date:** ____ - ____ - ____

Relationship to Patient ______

For phone interviews only:

- ☐ Pre-operative instructions
- ☐ Insurance card
- ☐ Co-payment
- ☐ Paperwork
- ☐ Directions
- ☐ Walker or crutches: bring with you
- ☐ Verification of Consent

Referred to anesthesia care team regarding ______

Phone interview completed (date/time): ______

IF YOU HAVE ANY QUESTIONS OR CONCERNS
A NURSE OR ANESTHESIOLOGIST WILL BE GLAD TO TALK WITH YOU !