

ANESTHESIA HEALTH QUESTIONNAIRE

Name:

Date of Birth:

Emergency Contact Name and Phone #:

*Home phone:

*Cell phone:

*Work Phone:

*E-mail Address:

Date of Surgery:	Height: FT. IN.	Weight:	Language spoken other than English/Communication needs:
Doctor(s)		Phone numbers	Date of last visit
*Primary Care Physician:			
*Cardiologist:			
Other Specialists:			
Pre-op testing to be completed at _____.			
Preferred Pharmacy Name _____		Address _____	Phone _____
Allergies and Reactions (Be Specific with Reactions) No Known Allergies ☐			
Medication Allergies/Reaction:			
Food:	Metal:	Tapes/Bandaids:	Latex:
X-ray/Contrast Dye:	Iodine Products:	Environmental:	

Name of Medication, Vitamins, Herbal Supplements (if you have a complete medication list, please forward with this form)	Dose	Directions for Use	Reason for Medication	Date Stopped

Pneumonia Vaccine month/yr _____	Flu Vaccine month/yr _____	Dentures?(Circle): Full / Partial / Upper / Lower
Please specify amounts and frequency:		
Cigarettes? Yes ☐ No ☐ Packs per Day _____ # Years _____	Past Use: Packs per Day _____ # Years _____	
Alcohol? Yes ☐ No ☐ _____	Recreational Drugs? Yes ☐ No ☐ Specify: _____	

Health History Assessment Continued; please check box if you have had a history of the following:

Neurological		Cardiovascular		Respiratory	
Stroke with residual		High blood pressure		Shortness of breath (# of blocks able to walk)	
Stroke without residual		Low blood pressure		Pneumonia	
Seizures		Aneurysm		COPD/ Emphysema	
Migraines/Headaches		Heart attack		Asthma	
Swallowing/Speech difficulty		Heart failure		Acute bronchitis	
Head injury/Concussion		Murmur /leaky valve		Chronic cough	
Confusion/Dementia		Chest pain/ Angina		Snoring	
Blackouts/fainting/dizziness		Irregular pulse/a fib		Sleep Apnea	
Numbness/tingling		Circulation problem		CPAP	
Head injury		Phlebitis/blood clots		TB	
Memory changes		Pacemaker/Defibrillator		Oxygen – how many liters	
Other		High Cholesterol		Seasonal Allergies	
		Cardiovascular intervention/Cardiac Catheterization/Stents		Other	
		Other			
Metabolic		Musculoskeletal		Genitourinary	
Diabetes Type 1		Arthritis/DJD		Burning	
Diabetes Type 2		Joint Replacement		Urgency	
Hypoglycemia-low blood sugar		Osteoporosis		Frequency	
Hypothyroid-low thyroid function		Osteopenia - low bone density		Blood in urine	
Hyperthyroid-overactive thyroid		Spinal/Back Problems		Recurrent Urinary Tract Infection	
Anemia		Muscle weakness/spasticity		Kidney failure/Dialysis	
Bleeding disorder		Fibromyalgia		Kidney Stones	
Obesity		Quadriplegic		Prostate problems	
Other		Paraplegic		Incontinence	
		Other		Ostomy	
				Other	
Psychosocial		Skin		Cancer/Hematologic/Infections	
Depression		Wounds		History of Cancer/ Type	
Panic/Anxiety attacks		Dry skin		Immunosuppression	
Claustrophobia		Rash or open areas		Ever been on isolation?	
Physical/Psychological Abuse		Body piercings/Tattoos		History of MRSA or Infectious Disease	
ADHD		Petechia/Bruising		Sexually transmitted disease	
Sensory Deficits		GI		GYN (females)	
Vision changes		Reflux		LMP/last menstrual period	
Hearing deficit		Ulcer		Possibility of Pregnancy?	
Hearing aids		Hiatal hernia		Post-menopausal (not menstruating longer than 1 year	
Macular degeneration		Hepatitis		Breast Feeding	
Glaucoma		Ostomy		Other	
Had surgery for Glaucoma		Change in bowel habits			
Cataracts		Diverticular disease			
Had surgery for cataracts		Crohn's disease/colitis			
Other		Constipation			
		IBS/ Irritable Bowel Syndrome			
		Other			
List of All Surgeries			Date Performed		

Have you had any problems with anesthesia?

Any family history of Malignant Hyperthermia?

Patient I.D.