ANESTHESIA QUESTIONNAIRE

Name: ____ Date: __________________________________

Age: ________________ Date of Birth: ___________________________ Sex: _____________________

Drug Allergies: ____

Medications: ____

____

Height: __________________________ Weight: ___________________________________

HISTORY: ***Please check Yes or No for each question***

Diabetes	☐ Yes ☐ No	Chronic Cough	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Heart Problems	☐ Yes ☐ No	Dizziness	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Mental Illness	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
Irregular Heartbeat	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Liver Disorder	☐ Yes ☐ No
Chest pains/Angina	☐ Yes ☐ No	Back problems	☐ Yes ☐ No	Blood Transfusion	☐ Yes ☐ No
Heart surgery	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No	Drink alcohol	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No	Smoke _____ Pks. Day	☐ Yes ☐ No	Bronchitis	☐ Yes ☐ No
Shortness of breath	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	HIV/Aids	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Prolonged bleeding	☐ Yes ☐ No	High temperature	☐ Yes ☐ No
Positive T.B. test	☐ Yes ☐ No	Blood in sputum	☐ Yes ☐ No	Weight loss	☐ Yes ☐ No
Night sweats	☐ Yes ☐ No				

Previous eye surgery type and approximate date: ____

____

Type of surgery and approximate date: ____

____

Other medical conditions: ____

____

Name of the doctor you see for regular health care: ____

Previous problems with anesthesia (you): ☐ Yes ☐ No

Previous problems with anesthesia (family members): ☐ Yes ☐ No

Signature: ____ Date: _____________________________

Information will be protected under HIPAA