Patient Questionnaire
Department of Anesthesia

Failure to fill out this form completely may delay your surgery

HAVE YOU EVER HAD:	YES	NO	DON'T KNOW	WHEN
Reaction to local/general anesthetic				
Family history of problems with anesthetic (e.g. malignant hyperthermia, allergic reaction)				
Difficulty Opening Mouth				
Difficulty Moving Neck				
Caps, bridges, crowns, dentures, loose teeth				
Heart Disease/Chest Pain/Heart Attack/angiogram/cardiac stents				
Heart valve disease/heart murmur				
Pacemaker/ICD				
High Blood Pressure				
Shortness of Breath				
Heavy snoring or sleep apnea				
IF Yes –do you have CPAP?				
Recent Cough/Cold				
Asthma/Wheezing/COPD				
Diabetes				
IF YES –on insulin?				
Epilepsy/seizures				
Stroke/"ministroke"/TIA				
Other Neurological disease (Cerebral aneurysm, neuromuscular disease)				

HAVE YOU EVER HAD:	YES	NO	DON'T KNOW	WHEN
Thyroid Problems				
Kidney Problems				
Hepatitis/Jaundice/liver disease				
Acid Reflux/Ulcer				
Cancer/Chemo/Radiation				
Back Problems				
Chronic Pain				
Autoimmune Disease (Rheumatoid arthritis, SLE)				
Artificial Body Parts (e.g. joint replacement)				
Contact lenses				
Bleeding/clotting problems				
Blood Thinners / Aspirin				
Cortisone/prednisone				
History of MRSA, VRE, Covid 19,				

Other disease not mentioned:

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Medications you take including Vitamins/Herbals:
(please include a list of meds from Pharmacist)

Medication	Dose	Frequency

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Possibility of Pregnancy: No ☐ Yes ☐
Recreational Street drugs:
Marijuana use: No ☐ Yes ☐ How much?________
Tobacco use: No ☐ Yes ☐ How much?________
Alcohol use: No ☐ Yes ☐ How much?________
Have you seen a Specialist in the last 5 years? Name and Phone # ☐ Heart Doctor (Cardiologist) ☐ Lung Doctor (Respirologist) ☐ Nerve Doctor (Neurologist) ☐ Other
Did you have or ever had any of the following Tests. When? ☐ Exercise stress test (Treadmill) ☐ Nuclear Medicine Stress Test ☐ Ultrasound of Heart (Echo) ☐ Holter Monitor ☐ Lung Function
List previous operations or admissions to a hospital. When?

Do you have allergies to medication, food, or latex? No ☐ Yes ☐

ALLERGY	REACTION

To Be completed by Nurse on day of Surgery :

Time of last fluid: **Time of Last Food:**

Age:_____ WT:_______ HT:_______ BP:_______

P:________ SaO2:_________ Temp:_________

Pre-admit nurse:

_______________________ Date:________

Day Of Surgery Nurse:

_______________________ Date:________

Comments:_________________________________