TEXAS SURGICAL CENTER

ANESTHESIA QUESTIONNAIRE

The answers to the following questions will aid in the planning of your anesthetic. Your anesthesia will be administered by:

_____ Anesthesiologist (physician)

_____ Certified Registered Nurse Anesthetist (under the direction of your surgeon)

Have you ever had surgery involving an anesthetic?

If yes, circle type:
Local General Spinal Epidural

Have you ever had a reaction/problem associated with any anesthesia? □ YES □ NO

What kind of problem?
High temperature?
Low blood pressure?
Other: _____

YES	NO	Anesthesia History/Other:
		Malignant Hyperthermia
		Previous Complication
		Postoperative Nausea or Vomiting
		Difficult Intubation
Other:		

Has a family member every had a problem with an anesthetic? □ YES □ NO
Please specify: _____

Do you have any of the following medical problems?

YES	NO	Respiratory:
		Sleep Apnea/CPAP at home
		Recent Respiratory Infection
		Asthma
		Smokeless Tobacco
		COPD/Emphysema
		Home Oxygen
		Prolonged Intubation History
		Snoring
Other:		

Do you smoke? □ YES □ NO

How many packs per day? _____
How long have you smoked? _____

Have you ever had a sleep study done? □ YES □ NO

When & what were the results? _____
_____
_____

YES	NO	Cardiovascular:
		Hypertension/ High Blood Pressure
		Angina/ Coronary Disease
		Heart Attack History
		Congestive Heart Failure History
		Stent/Angioplasty/Bypass Surgery
		Irregular Rhythm/Palpitations
		Heart Murmur/ Previous Echo
		Pacemaker/ Defibrillator
		Peripheral Vascular Disease
Other:		

YES	NO	GI/Hepatic/Renal:
		Frequent Reflux/ Ulcer
		Alcohol Use:_____
		Hepatitis/Liver Disease/Jaundice
		Nephrolithiasis
		Any Kidney Problems
		Dialysis-last done:_____
Other:		

YES	NO	Endocrine/Blood:
		Thyroid Disease
		Autoimmune Disease
		Steroids in previous six months
		Previous Blood Transfusion/HIV
		Bleeding Disorder/Anticoagulants
		Chemotherapy/Radiation History
		Rheumatoid Arthritis/ Lupus
Other:		

Are you a diabetic?
If yes, do you take medicine for your diabetes?
What medicine? _____
How often? _____

YES	NO	Neurologic:
		Seizure History
		Stroke/ TIA
		Chronic Back Pain/ Back Surgery
		Guillain-Barre/Polio/Spinal Cord
		Muscle Weakness/ Neuropathy
		Blackout/ Fainting
Other:		

PATIENT LABEL

	Y	N		Y	N
Have you had any previous surgery? If yes, please list: _____ _____ _____ _____ _____ **Do you or your family have any birth defects or congenital diseases?** If yes, please list: _____ _____ **Any hospitalizations in the last 6 – 12 months?** If yes, please list: _____ _____ _____ **Have you had any other major illnesses?** If yes, please list: _____ _____ **Do you have a history of MDRO (multi-drug resistant organisms) or infections? (ex. MRSA, VRE)** If yes, please explain: _____ _____ _____ **Would you rate your daily level of activity as:** Light Moderate Heavy Please explain the above activities:_____ _____ _____ **If under age 18, are your immunizations up to date?**			**If female, are you pregnant?** **Could you be pregnant?** Date of last menstrual period: _____ **Have you taken any ASPIRIN in the last 24 hours?** Last time you took ASPIRIN? _____AM / PM **Do you take CORTISONE or STEROIDS?** **Are you allergic to adhesive tape?** **Are you allergic to rubber or rubber products?** **Are you allergic to any medicines?** If yes, please list on the medication list page **Are you currently taking any medications?** If yes, please list on the medication list page **Do you have dentures?** Bridgework? Capped teeth? Loose teeth? **What is your weight?** _____ **What is your height?** _____ **What is your age?** _____		

_____ _____

Signature of patient/guardian Signature of Anesthesia Provider

_____ _____ _____ _____

Date Time Date Time

PATIENT LABEL

Revised 10/11/11