Name_____
Date of Birth_____
Phone #_____

North Hills Surgery Center
PATIENT PRE-ANESTHESIA QUESTIONNAIRE

Instructions: Please indicate if you have or have had any of the following. If you don't understand the question or are unsure of the answer, please leave it blank to discuss with the nurse.

Are you allergic to any medications or foods? Yes No
If yes, please list below with the reaction you had:
_____
_____
_____
_____
_____

Social History

Do you currently smoke or use tobacco products? Yes No
How many/how often: _____

Have you ever smoked? Yes No
How long? _____ When did you quit? _____

Do you drink alcohol? Yes No
If yes, how much, how often? _____

Do you or have you used any recreational or "street" drugs? Describe: _____ Yes No

Respiratory

Asthma or Wheezing? Yes No

Emphysema, COPD, or increased shortness of breath with activity? Yes No

Sleep apnea or been told that you have long pauses when you sleep? Yes No

Do you have difficulty laying flat? Yes No
How many pillows do you sleep on? _____

Wear supplemental oxygen? Yes No
If yes, how often, how much? _____

Cardiovascular

High Blood Pressure? Yes No

Heart Attack? Yes No

Angina or Chest Pain? Yes No

Irregular Heart beat? Yes No

"Heart failure" or any other heart problems? Yes No

Do you get shortness of breath when you walk around the grocery store? Yes No

Do you need to use a motorized cart? Yes No

Latex Allergy Screening

Have you ever had swelling, itching, or hives after contact with a balloon? Yes No

Are you allergic to bananas, papaya, avocados, kiwi, tomatoes, potatoes, or chestnuts? Yes No

Has a physician ever told you that you have a rubber or latex allergy? Yes No

CNS/GI

Epilepsy or Seizures? Yes No

Stroke, Paralysis, TIA or Meningitis? Yes No

Stomach or intestinal problems? Yes No

Gastroesophageal Reflux or heartburn? Yes No

Have you had a gastric bypass? Yes No

Have you ever had problems with an anesthetic? Yes No
If yes, was it malignant hyperthermia? Yes No

Has a blood relative ever had problems with an anesthetic? Yes No
If yes, was it malignant hyperthermia? Yes No

Have you ever been told that you were a difficult intubation? Yes No

Have you ever had nausea and vomiting after anesthesia? Yes No

Other

Liver problems, cirrhosis or hepatitis? Yes No

Thyroid problems? Yes No

Kidney problems? Yes No

Cancer? Yes No

Diabetes or high blood sugar? Yes No

Blood disease or bleeding problems? Yes No

Sickle cell disease? Yes No

HIV or AIDS? Yes No

Have you been pregnant within the past year? Yes No

Additional Information: _____
_____
_____
_____

Medications

***Past Surgical History*: (Please list surgery and year)**
_____
_____
_____
_____
_____
_____
_____
_____

Your time spent filling out this patient questionnaire is appreciated. It helps us provide you with the safest and best possible patient care. Thank you!

PAT Nurse: