ANESTHESIA QUESTIONNAIRE

1. Please fill out the **SHADED** areas on the following two pages.

2. To ensure your safety and comfort during anesthesia, please fill it out thoroughly.

DON'T FORGET TO LABEL ALL COPIES. IF NO LABEL, MUST INDICATE PATIENT NAME, DATE OF BIRTH AND DOCTOR
PATIENT NAME
DATE OF BIRTH
DOCTOR:
PLACE PATIENT ID LABEL HERE

SARASOTA MEMORIAL HEALTH CARE SYSTEM

ANESTHESIA PRE-OPERATIVE ASSESSMENT

Patient Name			Date		Age
Family Doctor	Cardiologist	Last visit	Pain Management Doctor	Other Doctor	

ALLERGIES (Include medications, food, tape, iodine, latex) **If you don't have allergies check here:** ☐ **No known allergies**

1.	2.	3.	4.	5.	6.

List of Daily MEDICATIONS (Including Over-The-Counter Medications and Dietary / Herbal Supplements)

Medication and Dose	Frequency	Medication and Dose	Frequency	Medication and Dose	Frequency
1.		5.		9.	
2.		6.		10.	
3.		7.		11.	
4.		8.		12.	

List Of SURGERIES (Include all surgeries and angioplasties)

Surgery	Year	Surgery	Year	Surgery	Year	Surgery	Year
1.		3.		5.		7.	
2.		4.		6.		8.	

Do you have or have you had any of the following? Check all that apply

☐ High blood pressure___________ ☐ Rheumatic Fever ☐ Murmur
☐ Heart Attack / MI Date ______ ☐ Congestive Heart Failure ☐ Palpitations
☐ Chest pain / Angina ☐ Irregular Heart Beat ☐ Dizziness / Fainting
☐ ICD / Pacemaker Model ______ ☐ Open Heart Surgery ☐ Blood clots / Phlebitis

Do you take blood thinners? Check all that apply

☐ Coumadin Last taken _____ ☐ Plavix Last taken _____ ☐ Aspirin Last taken _____
☐ Lovenox Last taken _____ ☐ Other ___________ Last taken _____

Have you had any of the following tests in the past? Complete all that apply

Date of last **EKG** ______ Where? _________________
Date of last **Stress Test** ______ Where? _________________
Date of last **Echo** ______ Where? _________________
Date of last **Cardiac Cath** _________ **Stent?** ☐ Yes ☐ No Where? _________________
Date of last **Pacemaker / Defibrillator** Check __________ Where? _________________
Date of last **Chest X-Ray** __________ Where? _________________

Do you have or have you had any of the following? Check all that apply

☐ Asthma ☐ COPD / Emphysema ☐ Cold or Flu past 2 weeks ☐ Bronchitis
☐ Cough ☐ Shortness of breath ☐ Pneumonia past 2 months
☐ Sleep Apnea ☐ CPAP / BIPAP ☐ Oxygen at home _________________
Do you: ☐ Snore ☐ Stop breathing in your sleep ☐ Have daytime sleepiness

Do you have or have you had any of the following? Check all that apply

☐ Diabetes. If yes, controlled by ☐ Insulin ☐ Pills ☐ Diet
☐ Kidney Disease Check all that apply: ☐ Renal Failure ☐ Dialysis ☐ Insufficiency ☐ Stones
☐ Liver Disease, Hepatitis or yellow jaundice
☐ Difficulty swallowing, esophageal cancer or esophageal surgery
☐ Cancer? If yes, type___________ Date_________ ☐ Chemotherapy ☐ Radiation
☐ Gastric Ulcer ☐ GERD (Reflux) ☐ Hiatal Hernia ☐ HIV or AIDS

Do you have or have you had any of the following? Check all that apply

☐ Thyroid Disease ☐ Anemia ☐ Bleeding Problems ☐ Arthritis
☐ Seizures. If yes, last one ______ ☐ Stroke Date ______ ☐ TIA
☐ Mental Illness ☐ Depression ☐ Other ________________________

Nursing Only

☐ **EKG** ordered
☐ **CXR** ordered

EKG ☐ Sent for ☐ On chart / Computer

Stress ☐ Sent for ☐ On chart / Computer

Echo ☐ Sent for ☐ On chart / Computer

Anti-Platelet Medication Management
☐ Sent for ☐ On chart / Computer

Cath ☐ Sent for ☐ On chart / Computer

CXR ☐ Sent for ☐ On chart / Computer

Last **dialysis** ____________

☐ **Labs** ordered

☐ **BBC** ordered
Number of units ______
☐ Blood products refused

PATIENT NAME

DATE OF BIRTH

PLACE PATIENT ID LABEL HERE

SARASOTA MEMORIAL HEALTH CARE SYSTEM

ANESTHESIA PRE-OPERATIVE ASSESSMENT

Do you have any of the following?

☐ Dentures ☐ Crowns ☐ Caps ☐ Bridge ☐ Loose, chipped, or broken teeth
☐ Contacts ☐ Glasses ☐ Cataracts ☐ Glaucoma ☐ Eye Implants
☐ Total joint/prosthesis: Type ____________

☐ Cochlear implant ☐ Insulin pump ☐ Pain Pump ☐ Other Implant ____________

Yes	No	
☐	☐	Have you or a blood relative ever had a problem with anesthesia?
☐	☐	Have you ever been told you had a difficult intubation?
☐	☐	Do you have a history of motion sickness or nausea / vomiting after surgery?
☐	☐	Are you being treated for a chronic pain condition?
☐	☐	Are you sensitive to pain medication or sleeping pills?
☐	☐	Are you claustrophobic or do you have an anxiety condition?
☐	☐	Do you consume alcohol? How much? ____________
☐	☐	Do you use recreational drugs? ☐ Occasional ☐ Daily Type ________
☐	☐	Do you smoke or did you ever smoke? How many years? ________ How much? ☐ 1/2 pack/day ☐ 1 pack/day ☐ 2 pack/day When did you quit? ____________
☐	☐	If female, are you pregnant or think you could be? Last menstrual period? ____________
☐	☐	Do you have difficult walking? Do you use? ☐ Cane ☐ Walker ☐ Wheelchair
☐	☐	Do you have difficulty walking two blocks at a normal pace?
☐	☐	Do you have difficulty walking up two flights of stairs?
☐	☐	Do you sleep on more than one pillow?
☐	☐	Do you wake up suddenly short of breath?
☐	☐	Are you currently in a drug study? Name of drug ____________

Form completed by ☐ Patient ☐ Other: ____________

ANESTHESIA COORDINATOR (if applicable)

Nursing Only

☐ Anesthesia Coordinator consulted
Old anesthesia record (if needed)
☐ SMH Date ________
☐ Other____________ Date________
☐ Sent for
☐ On chart

☐ Preg screen ordered
Reason not ordered ☐ Age > 60
☐ Hyst
☐ Meno

Height ________ Weight ________

Form Reviewed by:

____________ Date________

Date ____________ (Surgical Date)
BP ____________ P______ R______
Temp______ O2 Sat______
Accucheck______ Time______ ☐ NA
Form Reviewed by ____________

STOP, Section below for M.D. use only

Scheduled procedure: ____________
☐ Patient Pre-Anesthesia Questionnaire reviewed NPO Status: Last Food ____________ Last clear liquid____________

HX:

Pertinent Labs/Pertinent Diagnostics:

Physical:
Lungs ☐ CTA ☐ Other ____________
Heart: ☐ RRR ☐ Other ____________
Airway: ☐ Adequate ☐ Other ____________

ASA Classification: 1 2 3 4 5 E
Plan:

☐ SMH patient identification verified.
☐ Procedure consent verified.
☐ Risks, Benefits, Alternatives discussed with patient.
☐ Patient or guardian verbalizes understanding of anesthetic plan and wishes to proceed.

Preoperative Anesthesiologist: ____________ Date________ Time______

PATIENT NAME

DATE OF BIRTH

PLACE PATIENT ID LABEL HERE

SARASOTA MEMORIAL HEALTH CARE SYSTEM
ANESTHESIA PRE-OPERATIVE ASSESSMENT