PRE-ANESTHESIA QUESTIONNAIRE

Name	Age	Height	Weight
E-MAIL	**Physician/Surgeon**		
	Label		

Gender: [ ] Male [ ] Female

Ethnicity: [ ] Hispanic or Latino [ ] Not Hispanic or Latino [ ] Decline to State

RACE: [ ] Native/Alaskan American [ ] Asian [ ] Black/African American [ ] Native Hawaiian/Pacific Is.[ ] White [ ] Other [ ] Decline to State

Preferred Language [ ] English [ ] French [ ] Italian [ ] Japanese [ ] Portuguese [ ] Russian [ ] Spanish [ ] Other/Unknown

Please Mark All Boxes	YES	NO	Please List Any Allergies to Medications and/or Food		
Recent Cold/Flu			[ ] NONE		
Asthma/COPD/Emphysema					
Pneumonia/TB					
Chronic Cough					
Nighttime Snoring					
Sleep Apnea/CPAP					
Smoking [ ] Yes [ ] No [ ] Every Day [ ] Some Days [ ] Former [ ] Never					
Rheumatic Fever					
Heart Murmur					
High Blood Pressure			Please List All Medications and/or Supplements		
Low Blood Pressure					
Chest Pain/Angina			[ ] NONE		
Heart Attack/MI			Drug/Medication Name	Dose	Fequency
Irregular Heart Beat					
Palpitations					
Shortness of Breath					
How far can you walk without being short of breath? 1 2 3 or more blocks					
Pacemaker/AICD (Defib)					
Angioplasty or Stent			Please List Any Previous Surgeries		
Bleeding or Easy Bruising			[ ] NONE		
Jaundice/Hepatitis					
Acid Reflux/GERD					
Back or Neck Pain/Sciatica					
Arthritis					
Weakness/Numbness in Arms or Legs					
Disabling accident or Fall					
Epilepsy/Convulsions			Any Other Comments		
Stroke/CVA					
Paralysis/Polio					
Thyroid Disease					
Diabetes					
Kidney Disease					
Drink Alcoholic Beverages					
Recreational Drugs					
Blood Transfusions					
Denture/Caps/Loose Teeth			Internist/Family Doctor Name		*rev 9-25-10*
Dental Bonding/Laminates					
Motion Sickness/Vertigo					
Could You be Pregnant			Anesthesiologist Signature	Date	
Last Menstrual Period Date					
Unusual Reaction to Anesthesia in Past			Patient Signature	Date	