JANDEE
ANESTHESIOLOGY, PLLC
Ambulatory Anesthesia For A New Millennium

PRE-ANESTHESIA QUESTIONNAIRE

Name	Age	Height	Weight
Physician/Surgeon			

Do you, or have you had, any of the following medical conditions?

Please Mark All Boxes	**YES**	**NO**
Allergies of Any Type		
Recent Cold/Flu		
Asthma/COPD		
Pneumonia/TB		
Chronic Cough		
Emphysema		
Other Lung Trouble		
Nighttime Snoring		
Sleep Apnea		
Smoking		
Rheumatic Fever		
Heart Murmur		
High Blood Pressure		
Low Blood Pressure		
Chest Pain/Angina		
Heart Attack/MI		
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		
Bleeding or Easy Bruising		
Jaundice/Hepatitis		
Acid Reflux/GERD		
Back Pain/Sciatica		
Neck Pain		
Arthritis		
Weakness/Numbness in Arms or Legs		
Disabling accident or Fall		
Epilepsy/Convulsions		
Stroke/CVA		
Paralysis/Polio		
Thyroid Disease		
Diabetes		
Kidney Disease		
Drink Alcoholic Beverages		
Recreational Drugs		
Blood Transfusions		
Denture/Caps/Loose Teeth		
Other Dental Devices		
Dental Bonding/Laminates		
Motion Sickness		
Could You be Pregnant		
Last Menstrual Period Date		
Unusual Reaction to Anesthesia in Past		

Please List Any Allergies to Medications and/or Food

Please List All Medications and/or Supplements

Please List Any Previous Surgeries

Any Other Comments

Internist/Family Doctor Name

Anesthesiologist Signature	Date
Patient Signature	Date