



0500008

PLACE LABEL HERE.  
  
IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

**ANESTHESIA HISTORY QUESTIONNAIRE: For \_\_\_\_\_ Procedure**

Have you ever been to PETC or Outpatient Surgery Center before?  No  Yes  
 Do you have an Advance Directive (have you named a person[s] to speak for you if you are unable to speak for yourself)?  No  Yes If yes, where is a copy of the form located? \_\_\_\_\_

We will review your allergies and medicines with you. Please be sure we have a complete list.

List all of the **operations or surgeries** you have ever had:

| Operation | Date | Problems Anesthesia?                                     | If yes, details: |
|-----------|------|--|------------------|
|           |      | <input type="checkbox"/> No <input type="checkbox"/> Yes |                  |
|           |      | <input type="checkbox"/> No <input type="checkbox"/> Yes |                  |
|           |      | <input type="checkbox"/> No <input type="checkbox"/> Yes |                  |
|           |      | <input type="checkbox"/> No <input type="checkbox"/> Yes |                  |
|           |      | <input type="checkbox"/> No <input type="checkbox"/> Yes |                  |
|           |      | <input type="checkbox"/> No <input type="checkbox"/> Yes |                  |

| <b>Today</b> – Do you have?                 | If yes, details:   |
|---|--|
| A cough, cold, fever, or other illness      | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Contact lenses                              | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Glaucoma or vision problems                 | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Chipped or loose teeth                      | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Dentures, Caps, Crowns, Fixed bridgework    | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Hearing aid or hearing problems             | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Metal or plastic implants - valve, rod, pin | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Pacemaker or other heart device             | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| History of organ or tissue transplant       | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Ongoing or chronic pain                     | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Anxiety (worry) about surgery               | <input type="checkbox"/> No <input type="checkbox"/> Yes |

| <b>General Information:</b>   |    |     |                          |
|---|----|-----|--------------------------|
| Please Check No/Yes and add details   | No | Yes | Details                  |
| Do you ever use <b>alcohol</b> ? If yes,<br><input type="checkbox"/> Rarely <input type="checkbox"/> Daily <input type="checkbox"/> Weekly  |    |     |                          |
| Do you ever get high on <b>drugs</b> ? If yes,<br><input type="checkbox"/> Rarely <input type="checkbox"/> Daily <input type="checkbox"/> Weekly  |    |     |                          |
| Have you ever <b>smoked or used tobacco</b> ? If yes,<br><input type="checkbox"/> Chewing tobacco <input type="checkbox"/> Pipe/Cigar<br><input type="checkbox"/> Packs per day Cigarettes: |    |     | If you quit – Quit date: |
| Do you use CPAP, BiPAP or Oxygen?   |    |     |                          |
| <b>For Women:</b><br>Could you be, or are you, pregnant?  |    |     |                          |
| <b>For Children:</b><br>Was the child born prematurely?   |    |     | If yes, how early?       |
| Does the child have floppy or spastic muscles?  |    |     |                          |
| Does your child have any developmental issues?  |    |     |                          |
| Are immunizations (shots) up to date?   |    |     |                          |

How much **activity** are you able to do?  
Check Yes/No below

| Without stopping can you:  | No | Yes |
|--|----|-----|
| walk up 3 flights of steps or walk several blocks?               |    |     |
| walk up more than 1 flight of steps or 2 blocks?                 |    |     |
| walk up one flight of steps or less?                             |    |     |
| Do you get short of breath or have chest pain when lying in bed? |    |     |

- Why do you need to stop? (Check all that apply)
- Not applicable
  - Chest pain/pressure
  - Joint/back pain
  - Muscle cramps
  - Overweight
  - Short of breath
  - Weak, tired, dizzy

**HISTORY – HAVE YOU EVER HAD:** Check No or Yes and give details:

| Health problem  | No | Yes | Details: |
|---|----|-----|----------|
| <b>GENERAL</b>  |    |     |          |
| MRSA, VRE, CDIIF – require isolation or recent exposure to chicken pox, measles, mumps? |    |     |          |
| Cancer; please note type and treatment  |    |     |          |
| Diabetes or high sugar  |    |     |          |
| Severe heartburn or hiatal hernia   |    |     |          |
| Hepatitis or yellow jaundice  |    |     |          |
| Kidney failure  |    |     |          |
| Thyroid problems  |    |     |          |
| Tuberculosis, hepatitis or AIDS exposure  |    |     |          |
| Family member with problems with anesthesia   |    |     |          |
| <b>HEART/BLOOD</b>  |    |     |          |
| Chest pain, pressure or angina  |    |     |          |
| Heart attack  |    |     |          |
| Heart murmur  |    |     |          |
| Irregular heart beat  |    |     |          |
| High or Low blood pressure  |    |     |          |
| Abnormal electrocardiogram (ECG)  |    |     |          |
| Family member with heart attack before age 50   |    |     |          |
| Anemia (low blood count)  |    |     |          |
| Blood transfusion (If problems, give details)   |    |     |          |
| Excessive or easy bleeding  |    |     |          |
| Sickle cell disease   |    |     |          |
| <b>LUNGS</b>  |    |     |          |
| Asthma or wheezing, COPD  |    |     |          |
| Chronic or frequent cough   |    |     |          |
| Pneumonia   |    |     |          |
| Shortness of breath that wakes you up   |    |     |          |
| Abnormal chest x-ray  |    |     |          |
| <b>NEUROLOGICAL OR MUSCULOSKELETAL</b>  |    |     |          |
| Epilepsy or seizures  |    |     |          |
| Muscle disease  |    |     |          |
| Numbness in arms, hands, legs or feet   |    |     |          |
| Rheumatoid arthritis  |    |     |          |
| Weakness of an arm or leg or history of stroke  |    |     |          |
| Family member with nerve or muscle disease  |    |     |          |

At what phone number can you be reached the night before surgery? \_\_\_\_\_

What else should we know about you to help us care for you? \_\_\_\_\_

Please list current and past health care providers/facilities and their contact information:

(\*Provider Type includes but not limited to: primary care provider; cardiologist or other specialist; hospital where you received procedures such as MRI, cardiac catheterization, cardiac device, or stayed overnight.)

| Provider Name | *Provider Type | Address | Phone | Fax |
|---------------|----------------|---------|-------|-----|
|               |                |         |       |     |
|               |                |         |       |     |
|               |                |         |       |     |

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Name/if not patient — relationship to patient

If applicable:

Interpreted by (Name/Cyrcocom ID) \_\_\_\_\_ Date: \_\_\_\_\_