Anesthesia Patient Questionnaire

Today's date:

Patient Name(Last, First):_____ DOB:_____
Age: _____ Height: _____Weight:_____ Male /Female:_____
Address: _____ City: _____
State: _____ Zip: _____Cell: _____ Alternate Tel: _____
Email: _____
Responsible party's name: _____
Address: _____City: _____
State: _____ Zip: _____ Cell: _____ Alternate Tel: _____
Email: _____

Please circle the best number for doctor to reach you prior to your appointment.

INSURANCE INFORMATION

Insured's Name (Last, First): _____ DOB: _____
Primary Insurance: _____ Subscriber ID: _____
Secondary Insurance: _____ Subscriber ID: _____

Treatment Information:

Procedure: _____
Estimated Length of Procedure_____ Estimated Fee: _____
Appointment Date: _____
Surgeon: _____

Medical History

1) Have you had surgery or an anesthetic before? Yes ( ) No ( ) If yes, list:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Did you have any side effects? Yes ( ) No ( ) If yes, explain:

_____

2) Have you or any members of your immediate family had an unusual reaction to anesthesia? Yes ( ) No ( ) If yes, explain:

_____

3) Have you ever been diagnosed with a muscle disorder or have any muscular problems such as weakness, paralysis, spasticity, muscular dystrophy? Yes( ) No( ) If yes,
explain_____

_____

4) Are you allergic to any medications? Yes ( ) No ( ) If yes, please list:

_____
_____

5) Are you taking any medications at the present time? Yes ( )No ( ) If yes, please list

_____ _____ _____
_____ _____ _____
_____ _____ _____

6) Are you taking any blood thinning medications at this time? Plavix, Aspirin,Ibuprofen, Coumadin, Warfarin, Motrin, Excedrin etc …. Yes( ) No( ) If yes, please list:

_____

7) Are you using any over the counter, herbal or supplemental medications? Yes( ) No( ) If yes, please list:

_____

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8) Have you had a steroid therapy within the last year ? cortisone, prednisone etc
Yes( ) No( )

9) Have you had any heart problems such as congenital heart defects, murmurs, heart attacks,angina, heart stents, angioplasty, irregular heartbeat, congestive heart failure, Pacemaker, high blood pressure or shortness of breath, abnormal EKG? Yes( ) No( )
If yes, please list all that applies to you

_____ _____ _____
_____ _____ _____
_____ _____

10) Have you had any lung problems such as asthma, COPD, bronchitis, emphysema, recent cold or flu, chronic cough or tuberculosis? Yes( ) No( )
If yes, Please list all that applies to you:

_____ _____
_____ _____

11) Do you smoke? Yes( ) No( ) If yes, how many packs a day?_____ How many years?_____
12) Do you drink alcohol, beer, wine? Yes( ) No( ) If yes, how much per week? _____
13) Do you take any addicting drugs? Yes( ) No( ) _____ Which ? _____ last used when? _____
14) Do you have any stomach or abdominal problems such as reflux, hiatal hernia, nausea or difficulty swallowing? Yes( ) No( ) If yes, explain_____
15) Do you have diabetes, thyroid problems, or other abnormal hormonal disease? Yes( ) No ( ) If yes, list
_____
16) Have you ever had problems with your liver, such a hepatitis or yellow jaundice? Yes( ) No( ) If yes list_____
17) Do you have epilepsy, convulsions or seizures? Yes( ) No( )If yes, list_____
18) Have you ever had a stroke, speech difficulties or paralysis? Yes( ) No( ) If yes, list_____

19) Have you ever had any kidney problems such as kidney failure, dialysis? Yes( ) No( ). If yes list_____

20) Have you ever had any blood problems such as hemophilia, frequent nose bleeds, anemia, poor clotting, sickle cell, HIV or transfusions?
If yes list_____
21) Do you have other illnesses not listed? Yes( ) No( ) If yes, what?
_____
12) Please list all serious illnesses, hospitalizations or ER visits and dates.
_____

Do you have: ( ) Dentures ( ) Bridges
( ) Partial plates ( ) Caps
( ) Chipped Teeth ( ) Missing teeth
( ) Broken Teeth ( ) Loose Teeth
Could you be pregnant? _____

I understand that the accuracy of this health history is critical to the safety of general anesthesia. I have carefully answered all questions truthfully and to the best of my knowledge. **Please use the back of this form if more room is needed to complete the health history**. Thank you.
Signature _____ Date _____
Name _____
Relationship to patient _____

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