



ADULT ANESTHESIA PRE-OPERATIVE QUESTIONNAIRE

1. Does the patient have a history of complications or reactions to anesthesia, or history of a difficult airway or intubation? No Yes (If yes, please explain: _____)

2. Is there a family history of difficulty or complications with Anesthesia? No Yes

3. Does the patient have any known drug allergies? No Yes

4. Does the patient have any medical issues? Please list any. No Yes

5. Does the patient see a doctor for anything other than routine physical exams? No Yes

6. Does the patient see (or have they ever seen) any specialist doctors? (If yes, please explain)

Cardiology Pulmonology Neurology Urology Psychiatrist/Psychologist
Development Doctor ENT Doctor Dermatology Endocrinology Hematology
Oncology Other: _____ NONE

7. Please check the box if the patient has any of the following: (please explain and include severity)

Heart murmur Heart failure High blood pressure Chest pain/angina, heart attack
Irregular/rapid heart beat OR Irregular EKG Congenital heart defect
Pacemaker/AICD/implantable heart device History of stroke or mini stroke (TIA) Asthma
 Shortness of Breath Autism, ADHD, Developmental Delay, Cerebral Palsy Easy
bleeding, bruising, sickle cell disease, or other blood disorders Diabetes, thyroid problems, or
other endocrine condition Heartburn (GERD) Cancer history Genetic syndromes
(Trisomy 21, or other) NONE

7. Has the patient ever had surgery and/or anesthesia? If yes, please list type of surgery and year. No Yes

8. Does the patient snore or have sleep apnea? No Yes

9. Has the patient had a cough or cold symptoms now or in the last 2 weeks? No Yes

10. Has the patient ever stayed overnight in the hospital? If yes, for what reason. No Yes

11. Substance use history. Please check all that apply.

Current Smoking/tobacco (packs/day and years: _____)



Past History of smoking/tobacco (when stopped and years of use: _____)

Marijuana products

Non-prescription drugs (cocaine, methamphetamine, speed, crack, other)

Recovering addict or alcoholic

NONE

12. Exercise tolerance. Please check all that apply.

Can walk up 2 flights of stairs without shortness of breath

Can walk around the block without shortness of breath

Can walk two blocks on level ground at 2 to 3 mph

Can walk up a hill or at a brisk pace (4 mph)

Can participate in strenuous sports (swimming, singles tennis, or jogging)

13. Women Only: Pregnancy Waiver I understand that pregnancy testing is not available and that anesthesia can have consequences for fetal development. I certify that there is no possibility that I am pregnant and waive the opportunity to conduct a pregnancy test.

Yes, I understand and waive

No, I would like to postpone the procedure

14. Height and Weight

Height (please indicate inches or cm): _____

Weight (please indicate lbs. or Kg.): _____