## ANESTHESIA QUESTIONNAIRE

YOUR DOCTOR HAS ARRANGED FOR YOU TO RECEIVE ANESTHESIA. YOUR ANSWERS TO THE FOLLOWING QUESTIONS WILL GREATLY HELP THE ANESTHESIA PROVIDER TO GIVE YOU HIS OR HER BEST CARE DURING YOUR PROCEDURE. PLEASE INDICATE BY A CHECK ( √ ) YOU'RE ANSWER TO EACH QUESTION. IF YOU DO NOT UNDERSTAND ANY QUESTION OR YOUR ANSWER IS UNCERTAIN, PLEASE PLACE A QUESTION MARK ( ? ) IN THE YES OR NO COLUMN.

**Have you ever had an anesthetic in the past? ( ) YES ( ) NO Date of last anesthetic _____ Hospital_____**

| DATE | LIST ALL PREVIOUS SURGERIES |
|---|---|
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| | |

| | Yes/No | Comments |
|---|---|---|
| Have you or a close relative ever had a problem with anestetic? | | |
| Are you allergic to any medication? IF YES PLEASE LIST | | |

**LIST ALL MEDICATIONS AND DOSAGES YOU ARE TAKING OR HAVE TAKEN WITHIN THE LAST 30 DAYS INCLUDING OVER THE COUNTER MEDICATIONS. IF NEED MORE SPACE SEE ATTACHED.**

| MEDICATION | DOSAGE & TIMES TAKEN |
|---|---|
| | |
| | |
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| | |

**HEIGHT** **WEIGHT**

| | | |
|---|---|---|
| Are you currently pregnant? | **( ) YES** | **( ) NO** |
| History of sexual, emotional, or physical abuse? | **( ) YES** | **( ) NO** |
| **Have you had or still have:** | **YES** | **NO** |
| Meningitis | | |
| HIV/AIDS | | |
| STD | | |
| C-Diff | | |
| MRSA | | |

**ANESTHESIOLOGIST USE ONLY**

ASA Level: 1 2 3 4 5 E

Anesesthesia Plan: ( ) General ( ) Local ( ) MAC ( ) Other

**THIS IS NOT CONSENT FOR ANESTHESIA!**

**X**_____

**Signature of patient or representative**

| HAVE YOU HAD OR STILL HAVE: | YES | NO | PATIENT, MD, CRNA, OR NURSE COMMENTS |
|---|---|---|---|
| A cold or chronic cough | | | |
| Bronchitis or pneumonia | | | |
| Asthma | | | |
| Tuberculosis | | | |
| Hay fever | | | |
| Emphysema | | | |
| Shortness of Breath | | | |
| COPD | | | |
| Any other lung trouble | | | |
| Do you smoke | | | Per Day: Years: |
| Do you drink alcohol | | | Per Day: Years: |
| Rheumatic Fever | | | |
| Heart murmur/ CHF | | | |
| Chest pain/ Angina | | | |
| Heart Attack/ Pacemaker | | | |
| Stroke/ Numbness/Polio | | | |
| Blood pressure trouble | | | ( ) High ( ) Low |
| Anemia | | | |
| Sickle cell or hemophilia | | | |
| Jaundice, hepatitis, liver trouble | | | Hepatitis: ( ) A ( ) B ( ) C |
| Infectious Mononucleosis | | | |
| Gall bladder trouble/removal | | | |
| Back pain or injury | | | |
| Slip disc or sciatica | | | |
| Convulsions/ seizure/epilepsy | | | |
| Mental Illness | | | |
| Thyroid problems | | | |
| Diabetes | | | |
| Low blood sugar | | | |
| Kidney trouble (dialysis/stone) | | | |
| Illegal drug use | | | What/ How often: |
| Prescription drug **abuse** | | | What/ How often: |
| Blood transfusion | | | When: Any Reaction: |
| Dentures or loose teeth | | | |
| Contacts or glasses | | | |
| Prothesis | | | |
| Malignant Hyperthermia | | | |
| Sleep Apnea | | | |
| Any other illness not listed | | | |

**LAKE CITY SURGERY CENTER, LLC**
**ANESTHESIA QUESTIONNAIRE**

**PATIENT STICKER**