PLEASE COMPLETE THIS FORM PRIOR TO YOUR PRE-ANESTHETIC EVALUATION

I AGREE TO HAVE NOTHING BY MOUTH AFTER MIDNIGHT THE NIGHT BEFORE MY SURGERY UNLESS INSTRUCTED TO DO SO.

Height_____ Weight_____ Age_____

Allergies (Medication, Latex, Food, Other) _____

YES_____ NO_____ Is this your first anesthetic?

YES_____ NO_____ Have you ever had problems with anesthesia? Specify _____

YES_____ NO_____ Have members of your family had problems with anesthesia? Specify_____

YES_____ NO_____ If female, date of last menstrual period? (If menopausal include year of last period) _____

YES_____ NO_____Are you or could you be pregnant?

YES_____ NO_____Are you currently taking any prescription/over-the-counter medications, herbal, and/or dietary supplements;

list medication & dosage _____

_____

_____

DO YOU HAVE OR HAVE YOU HAD:

YES_____ NO_____ Heart disease (including: heart murmur, pacemaker, catheterization, stents, surgery, mitral valve prolapse)

Specify _____

YES_____ NO_____ Chest pain Do you exercise regularly? YES_____ NO_____ What type _____

YES_____ NO_____ Previous EKG/stress test/echocardiogram Date(s) _____

YES_____ NO_____ High blood pressure

YES_____ NO_____Asthma Hospitalizations YES_____ NO_____ how many_____

YES_____ NO_____ Lung disease Specify _____

YES_____ NO_____ Chronic cough

YES_____ NO_____ Shortness of breath

YES_____ NO_____ Sleep apnea CPAP YES_____ NO_____

YES_____ NO_____Abnormal chest x-ray

YES_____ NO_____ Kidney disease Specify_____Difficulty voiding YES_____ NO_____

YES_____ NO_____ Liver disease/Hepatitis/Jaundice Specify _____

YES_____ NO_____ Diabetes Year diagnosed_____ Do you take insulin? YES_____ NO_____

YES_____ NO_____Are you on a special diet? Specify _____

YES_____ NO_____ Recent weight loss how much _____

YES_____ NO_____ Epilepsy/Seizures/Stroke/Neurological problems Specify_____

EMORY HEALTHCARE

Pre-Anesthetic Questionnaire

Patient Information/Label

YES_____ NO_____Autoimmune disorders/Connective tissue disorders/Lupus/Sarcoid Specify _____

YES_____ NO_____ Psychological conditions (depression, anxiety, bipolar disorder, schizophrenia, etc.) Specify_____

YES_____ NO_____ Thyroid or goiter problems Specify _____

YES_____ NO_____ Bowel/colon disease or problems Specify _____

YES_____ NO_____ Frequent heartburn/indigestion, esophageal reflux, hiatal hernia

YES_____ NO_____ Glaucoma Use eye drops YES_____ NO_____

YES_____ NO_____ Back and/or neck problems Specify _____

YES_____ NO_____ Muscle weakness Specify_____

YES_____ NO_____ Metal implants (back, hip, knee, etc) Specify _____

YES_____ NO_____ Past/present carrier of contagious/infectious disease Specify _____

YES_____ NO_____ Exposure to communicable diseases in the past 3 weeks Specify _____

YES_____ NO_____ Bleeding or clotting abnormalities Specify _____

YES_____ NO_____ History of blood transfusions Specify _____

YES_____ NO_____ Nose surgery

YES_____ NO_____ Broken bones in face, back or neck Specify_____

YES_____ NO_____ Do you or have you ever smoked? amount per day_____how many years_____year quit _____

Use(d) smokeless tobacco how many years_____year quit_____

Use(d) recreational drugs type(s)_____how much_____how many years _____

Use alcohol type(s)_____how much_____

Been treated for substance abuse type(s)_____when _____

YES_____ NO_____ Steroid use in the past 12 months Specify _____

DO YOU HAVE ANY OF THE FOLLOWING?

Dentures_____Partial plate_____Bridgework-permanent_____Caps/Crowns_____Chipped/Missing teeth_____

ARE YOU WEARING ANY OF THE FOLLOWING?

Contact lens_____False eyelashes_____Wig/hairpiece_____Hearing aid_____

LIST ADDITIONAL MEDICAL/SURGICAL PROBLEMS: _____

_____

LIST PREVIOUS SURGERIES: _____

_____

PATIENT SIGNATURE	PARENT, GUARDIAN, OR NEXT OF KIN (if patient. unable to sign)	RELATIONSHIP

EMORY HEALTHCARE

Pre-Anesthetic Questionnaire

Patient Information/Label