Date _____ Age _____ Height _____ Weight _____

Have you had? (circle problem) (Patient complete)

1. Heart problems, congestive heart failure, heart attack, high blood pressure, heart murmur, abnormal cardiogram, blood clots yes no
2. Lung disease: asthma, emphysema, bronchitis abnormal chest x-ray, tuberculosis yes no
3. Sleep Apnea yes no
4. CPAP machine yes no
5. Seizures, glaucoma, nervous system disease, stroke, muscle weakness, paralysis yes no
6. Jaundice, hepatitis, cirrhosis yes no
7. Kidney or bladder disease, stones, severe infection yes no
8. Metabolic problems: diabetes, thyroid, adrenal, etc. yes no
9. Back injuries or surgery, broken bones yes no
10. Stomach or intestinal problems, ulcers, colitis, hiatal hernia, reflux, gastritis yes no
11. Blood transfusions Date _____ yes no
12. Objections to blood transfusions yes no
    Even if life in danger yes no
13. Blood disease, abnormal bleeding tendencies yes no
14. Anticoagulant therapy (blood thinners) yes no
15. Are you pregnant? LMP-_____ maybe yes no
16. Other medical illness yes no
17. When did you last eat or drink anything? _____

Do you

1. Smoke? yes no pkg/pd _____ years _____
   Quit smoking? (date) _____
2. Use alcohol? none social moderately heavy
3. Have a history of substance abuse? yes no
4. Wear eyeglasses/contacts? yes no Contacts in out
5. Denture ▲ ▼ bridges ▲ ▼ caps ▲ ▼ none
6. Loose/damaged teeth ▲ ▼ none

Previous Anesthetic history:

1. Date of last anesthetic _____
2. Any abnormal reactions yes no
3. Relatives with abnormal reactions to anesthesia yes no
4. Comments: _____

List previous surgeries (type and date)

1. _____
2. _____
3. _____
4. _____
5. _____

List all medications you are presently taking.

Aspirin – how many a day _____

	Dosage	Freq	Last Dose
1.			
2.			
3.			
4.			
5.			

List Allergies (drug, foods)	Reaction
1.	
2.	
3.	
4.	
5.	

Patient Signature _____

Anesthesia Evaluation (Anesthesia complete)

Date _____ Time _____ NPO _____

Rx medication before surgery: _____

History and physical _____

Airway: _____

Anesthesia benefits/options with attendant risks and complications discussed with patient/family. **Questions** answered. yes no Understands yes no

Procedure proposed: _____

Plan _____ Informed consent given by _____

Anesthesiologist: _____

Reviewed by: _____ R.N.

Vital Signs

Temp _____ BP _____ P _____ R _____

Time _____

Postoperative

Admit to recovery room: _____

O2 sat. _____% BP _____ P _____ R _____

☐ Awake
☐ Good spontaneous ventilation
☐ No Anesthetic complications

Anesthesiologist: _____

Lakeside Women's Hospital

ANESTHESIA QUESTIONNAIRE AND EVALUATION

(PLACE PATIENT'S LABEL HERE)