Coast Surgery Center

PRE-ANESTHESIA SURGERY QUESTIONNAIRE

Surgeon: _____
Date of surgery: _____

Name: _____
Home phone #: _____

phone # where you can be reached at night: before surgery: _____

The answer to the following questions help your anesthesiologist provide the safest & most indivisually appropriate anesthesia for *you*. Please check *only* **YES, NO,** or ?. If you select YES or ?, the anesthesilolgist will document your explanation.

PATIENT CHECK LIST

Yes	No	?	
			Age_____ **Height** _____ **Weight** _____ **lbs.**
❒	❒	❒	1. Have you had SURGERY before?
❒	❒	❒	2. Any **problems with ANESTHESIA**? *(i.e., nausea, vomiting, dizziness, headaches, low blood pressure)*
❒	❒	❒	3. Has any ***blood relative*** had a problem with Anesthesia?
❒	❒	❒	4. Have you ever had ***motion sickness***?
❒	❒	❒	5. Do you have any loose teeth, dentures, bridges, or limitation opening mouth?
❒	❒	❒	6. Have you ever had an ALLERGIC REACTION to any medication, foods or **latex**? If yes, what were they? _____
❒	❒	❒	7. **Your family physician's NAME** _____ **Your family physician's PHONE #** (_____) _____
			8. Do you have any **MEDICAL PROBLEMS**? *(Circle)*
❒	❒	❒	CARD-Coronary Artery Disease, Angina, Palpitations,Murmurs, Hypertension
❒	❒	❒	PULMONARY - Asthma, Bronchitis, Emphysema, Hay Fever
❒	❒	❒	LIVER - Hepatitis, Jaundice, Blood Transfusion reaction
❒	❒	❒	KIDNEY - Renal Stones, Bladder Infections
❒	❒	❒	ENDOCRINE - Diabetes, Hypoglycemia, Thyroid Disease, Other
❒	❒	❒	NEUROLOGY- Fainting Spells, Seizures, Convulsions, Migraines
❒	❒	❒	MUSCULO-SKELETAL - Disc Disease, Back/Neck Pain, Arthritis, Bursitis
❒	❒	❒	GASTRO-INTESTINAL -Ulcers, Gastritis, Reflux, Hiatal Hernia, Obesity
❒	❒	❒	9. Do you Smoke? If yes, how much? _____
❒	❒	❒	10. Have you ever had an **abnormal** EKG, chest x-ray, or blood test?
❒	❒	❒	11. Have you had any Serious Illnesses requiring Hospitalization? If Yes, explain: _____
❒	❒	❒	12. Do you have any other Medical Condition? _____
❒	❒	❒	13. Have you had a cold in the past 2 weeks? If yes, what were the symptoms? *(fever, chills, sore throat,* _____*)*
❒	❒	❒	14. Within the last 2 weeks, have you been exposed to any communicable diseases? *(i.e., chicken pox, mumps, measles /rubeola, or German measles/rubella)*
❒	❒	❒	15. Are you pregnant at this time?
❒	❒	❒	16. Are you trying to get pregnant at this time?
❒	❒	❒	17. Do you take MAOI, Fen/Phen, or St.John's Wort? If Yes, you **must** discontinue use at least 2 weeks prior to surgery.

18. List **ALL MEDICATIONS** taken routinely, including diet pills / herbal supplements:
***We also recommend that you discontinue the following medications for at least 2 weeks prior to surgery *if clinically tolerated*: Serzone, Prozac, Celexa, Effexor, Wellbutrin, Zoloft, Zyban, Paxil, Luvox, Trazodone, Meridia, and phenteramine.
19. **Circle** ANY Pain Medications you have taken. If you tolerate any without nausea, vomiting, or dizziness, **circle** the adjacent "OK":
Tylenol - OK Codeine - OK Darvon - OK
Vicodan - OK Percodan - OK

ADDITIONAL HX BY ANESTHESIOLOGIST

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Physical Exam:
HEENT:
Chest:
Cardiac:
Other:

ASA: I II III
Plan:

Anesthesia risks, indications, alternative and plan have been discussed with patient & patient agrees.

Anes. Sig. _____ MD
Date: _____ Time: _____

CONSENT: _____ _____
Signature of patient (or legal guardian of patient) consenting for anesthesia *Date*

(Place Patient Label Here)