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