ANESTHESIA QUESTIONNAIRE

Patient: Please Answer Each Question

Primary Care Provider: ________________________________

Height: _______ Weight: _______

<table>
<thead>
<tr>
<th>All Previous Operations</th>
<th>Year</th>
<th>Were you awake or asleep?</th>
</tr>
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<tbody>
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Please indicate any problems you have had from surgery or anesthesia: ____________________________

Do you have any specific concerns or questions about your anesthetic? Yes No

Have any of your blood relatives had any unusual problems from anesthesia? Yes No

Have any of your blood relatives had any blood clotting disorders? Yes No

Have you been admitted to a hospital in the last 6 months? Yes No

What was the reason/diagnosis? ____________________________

Do you exercise regularly? Yes No

Can you climb one flight of stairs without getting fatigued or short of breath? Yes No

Can you climb two flights of stairs without getting fatigued or short of breath? Yes No

Are you taking any blood thinners or anticoagulants? Yes No

Have you taken in the last 2 weeks:

- warfarin (Coumadin) Date of last dose: ____________
- enoxaparin (Lovenox) Date of last dose: ____________
- clopidogrel (Plavix) Date of last dose: ____________
- ticlodipine (Ticlid) Date of last dose: ____________

Please list any allergies you have:

Allergic To: __________________ What Happens? __________________

Women of child-bearing age:

Could you be pregnant now? Yes No

When was your last period? ____________________________

Have you had sex without using birth control since your last period? Yes No

Do you smoke?

Packs per day: ____________________________

When did you quit smoking? ____________________________

Do you have any breathing problems?

- Asthma
- Bronchitis
- Emphysema
- Sleep Apnea
- Shortness of Breath

Have you had a recent cold? Yes No

Do you have high blood pressure? Yes No

Do you have vascular disease? Yes No

Do you have any heart problems?

- Angina / Chest Pain
- Heart Attack
- Heart rhythm problems
- Pacemaker
- Heart valve condition
- Congestive Heart Failure

Do you have stomach problems?

- Ulcers
- Hiatal Hernia
- Severe Heartburn
- Gastroesophageal reflux

Do you drink alcohol? Yes No

Have you had liver disease? Yes No

- Hepatitis

Do you have kidney disease? Yes No

Do you have diabetes? Yes No

Have you ever had epilepsy or a convulsion? Yes No

Do you have back trouble? Yes No

Do you have numbness or tingling in your arms or legs? Yes No

Have you or any of your blood relatives had a history of anemia? Yes No

Have you ever had a blood transfusion? Yes No

Did you have a reaction to the transfusion? Yes No

Other medical problems: ____________________________

Do you have loose, false, or capped teeth? Yes No

Do you wear glasses/contact lenses? Yes No

Completed by: ____________________________
### Physical Exam

<table>
<thead>
<tr>
<th>Mental Status</th>
<th>NL</th>
<th>Confused</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airway</td>
<td>C Spine ROM</td>
<td>NL</td>
<td>Limited</td>
</tr>
<tr>
<td>Mouth Opening</td>
<td>NL</td>
<td>Limited</td>
<td></td>
</tr>
<tr>
<td>View of Posterior Pharynx</td>
<td>Class I</td>
<td>Class II</td>
<td>Class III</td>
</tr>
<tr>
<td></td>
<td>Mental–hyoid distance: ____________ Fingerbreadths</td>
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<tr>
<td>Dentition</td>
<td>NL</td>
<td>Dentures</td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td>Clear to Auscultation</td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td>RRR without Murmur</td>
<td>Other</td>
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**Anesthesiologist’s Comments:**

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

**NPO Status:**

**ASA Classification:** 1 2 3 4 5 Emergency Surgery

After review of this form and examination of this patient, the following anesthetic is proposed:

- MAC
- GA
- Spinal
- Epidural
- CSE
- Epidural if needed post–op
- Interscalene
- Axillary
- Ankle block
- CVP
- Femoral / ____________
- IV Regional
- Art line
- CSE
- CVP
- Femoral / ____________
- Ankle block
- DNR status discussed

_____________ MD / DO  _______________ Date / Time