SURGICAL HOSPITAL OF OKLAHOMA

ANESTHESIA QUESTIONNAIRE

Patient Information: (Answers are important to your safety) DO NOT LEAVE ANY BLANKS.

Have you ever had the following:	YES	If So, When	NO
Heart trouble	☐	______	☐
High blood pressure	☐	______	☐
Lung disease	☐	______	☐
Asthma	☐	______	☐
Diabetes	☐	______	☐
Stroke	☐	______	☐
Kidney disease	☐	______	☐
Anticoagulant therapy (blood thinners)	☐	______	☐
Epilepsy or seizures	☐	______	☐
Blood disease	☐	______	☐
Paralysis/Muscle Weakness/ Muscular Dystrophy	☐	______	☐
Arthritis	☐	______	☐
Peptic ulcer disease	☐	______	☐
Hiatal hernia	☐	______	☐
Jaundice/Hepatitis/Liver Disease	☐	______	☐
Blood vessel disease (phlebitis, etc.)	☐	______	☐
False or loose teeth	☐	______	☐
Dental caps or bridges	☐	______	☐
Fracture of facial bones	☐	______	☐
Fracture of neck or back	☐	______	☐
Glaucoma	☐	______	☐
Chest x-ray in past year	☐	______	☐
Electrocardiogram in past year	☐	______	☐
Did you take medication Prior to coming to center?	☐	______	☐
If female or childbearing age: Are you or could you be **pregnant**?	☐	______	☐
Date of last period ____________			
Have you been exposed to Tuberculosis In the past six months?	☐	______	☐
Personal/Family History of **Malignant Hyperthermia**	☐	______	☐
Any use of herbal medications	☐	______	☐
If so what ________________			

Other Medical Illness:
List ______________________
____

Are you allergic to **Latex**? YES ☐ NO ☐
Oral Sensitivity to Avacado, Banana, Kiwi, Chestnuts? YES ☐ NO ☐
Do you: Smoke ______ pkg/day? YES ☐ NO ☐
Use alcoholic beverages? YES ☐ NO ☐
If so: ☐ 1-5/wk ☐ 5-10/wk ☐ >10/wk
Wear contact lenses? YES ☐ NO ☐
Use recreational drugs? YES ☐ NO ☐
If so what ____________________
Any Body Piercings? YES ☐ NO ☐
If so where ____________________

A. AGE _________ WT lbs __________ kgs __________ HT __________

B. TIME OF LAST
FOOD OR DRINK ______________________
MEDICATION TAKEN TODAY? YES☐ NO☐
IF YES, PLEASE LIST ______________________
____
TAKEN WITH WHAT? ______________________

C. PREVIOUS ANASTHETIC RECORD
DATE LAST ANASTHESIA ______________________
ANY ABNORMAL REACTIONS YES☐ NO☐
RELATIVES WITH ABNORMAL REACTIONS? YES☐ NO☐

D. LIST PREVIOUS SURGERIES (TYPE & DATE)
____
____
____
____
____
____
____
____
____

E. LIST MEDICATIONS YOU ARE PRESENTLY TAKING ______________________
____
____
____
____
____
____
____
____

ASPIRIN? YES☐ NO☐
HOW MANY A DAY __________
HOW MANY A DAY __________
ANY OTHER ARTHRITIS TYPE MEDICATION? YES☐ NO☐

Are you allergic to any medications? YES☐ NO☐
If yes, list medication and type of reaction you had
____
____
____
____
____
____
____
____

X
____
Patient Signature Date