Surgical Hospital Of Oklahoma

Anesthesia Questionnaire

DO NOT LEAVE ANY BLANKS. ANSWERS ARE IMPORTANT TO YOUR SAFETY

Age: __________ Height: __________ Weight: __________lbs __________kgs

Are you or could you be pregnant? ❐ Not applicable ❐ Yes ❐ No Date of last menstrual period: _______

Time of last food or drink: _______________

Primary Care Physician's name and phone number ____

Health History

Have you ever had the following:	Yes	No	Date
Heart Trouble	❐	❐	____________
High blood pressure	❐	❐	____________
Lung disease	❐	❐	____________
Asthma	❐	❐	____________
Diabetes	❐	❐	____________
Stroke	❐	❐	____________
Blood clot in leg or lungs	❐	❐	____________
Kidney disease	❐	❐	____________
Anticoagulant Therapy	❐	❐	____________
Epilepsy/Seizures	❐	❐	____________
Blood disease	❐	❐	____________
Paralysis/ Muscle weakness	❐	❐	____________
Muscular Dystrophy	❐	❐	____________
Sleep Apnea	❐	❐	____________
CPAP machine	❐	❐	____________
Arthritis	❐	❐	____________
Peptic Ulcer disease	❐	❐	____________
Hiatal Hernia	❐	❐	____________
Jaundice	❐	❐	____________
Hepatitis/Liver disease	❐	❐	____________
Mark type (if known):	A___	B ___	C ___ Other: ____
Blood vessel disease	❐	❐	____________
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	❐	❐	____________
Exposure to Tuberculosis in the past six months	❐	❐	____________

Do You:

	Yes	No
Smoke _______ pk/day?	❐	❐
Drink alcoholic beverages?	❐	❐

If yes: ❐ 1-5/wk ❐ 5-10/wk ❐>10/wk

	Yes	No
Wear contact lenses?	❐	❐
Use recreational drugs?	❐	❐

If yes, please list ____

	Yes	No
Have any body piercings?	❐	❐

If yes, where ____

Other Medical Illness: ____________________________________

____

____

____

____

Medications and Allergies

	Yes	No
Are you allergic to Latex?	❐	❐
Do you have oral sensitivity to Avocado, Banana, Kiwi, or Chestnuts?	❐	❐
Are you allergic to any food or drugs?	❐	❐

If yes, please list name and reaction:

Name:__________________Reaction: ____________________

Name:__________________Reaction: ____________________

Name:__________________Reaction: ____________________

Name:__________________Reaction: ____________________

Name:__________________Reaction: ____________________

Name:__________________Reaction: ____________________

Did you take any medication today? Yes ❐ No ❐

If yes, please list: ______________________________________

____

What did you swallow it with? _________________________

Do you use herbal medications? Yes ❐ No ❐

List Medications you are currently taking (include herbals)

____

____

____

____

____

____

____

____

Do you take aspirin? Yes ❐ No ❐

If yes, how many per day __________ last dose____________

Any other type of arthritis medication? Yes ❐ No ❐

Anesthesia and Surgical History

Date of last anesthesia: ________________________________

Any abnormal reactions? Yes ❐ No ❐

Any relatives with abnormal reactions? Yes ❐ No ❐

Personal/Family History of **Malignant Hyperthermia** Yes ❐ No ❐

List Previous Surgeries	**Date**

X____

Patient Signature Date