PRE-ANESTHESIA QUESTIONNAIRE

DATE PROCEDURE_____
PATIENT NAME:_____
PERSONAL PROFILE Occupation_____
History Obtained By: Patient ☐ Other ☐_____
Age _____ Weight _____ Height _____

Family History (Including All Blood Relatives and Yourself)
☐ Bleeding Problems
☐ High Fever during or after surgery
☐ Severe reactions / death caused by anesthetics

Patient only the following are patient health questions only
☐ Have you ever had swelling, itching, hives or any reaction to latex, ruber or elastic?
☐ Are you allergic to any medication or foods? If so, list with reactions _____
_____
_____
Reactions: Trouble Breathing ☐ Hives ☐ Swelling ☐ Nausea ☐
Other:_____
☐ Have you ever smoked cigarettes, cigars, pipes? If so: How many ____ packs per day. How many _____ years. If you have quit, when did you quit? _____
☐ Do you drink alcoholic beverages? Beer, Wine, 80+Proof
How much _____ How often _____
☐ Have you **ever** taken any street drugs by any route of administration? Please list_____
☐ If Female, is there **any** possibility you are currently pregnant?
☐ Are you breasting feeding?
☐ Do you have contact lenses?
☐ Do you have loose, missing or damaged teeth? Temporary fillings? ☐ Dentures or Bridges? ☐
☐ Do you have any difficulty fully opening your mouth or bending your neck?
☐ Have you ever taken Warfarin, Blood thinners, Steroids or Cortisone?

Primary Care Doctor _____
Date Last Seen _____

SURGICAL, PROCEDURE AND SEDATION HISTORY

Year	Type of Surgery/Procedure & Sedation	Complications

PATIENT IDENTIFICICATION LABEL

PAST HISTORY (Have you ever had any of the following conditions if yes please check the appropriate box.)

☐ Heart Disease ☐ Heart Attack/Year_____
☐ Heart Murmur ☐ Mital Valve Prolapse
☐ Chest Pain ☐ Irregular Heart Beat
☐ High Blood Pressure Medication_____
☐ Diabetes ☐ Type 1 ☐ Type 2
☐ Pneumonia ☐ Chronic Bronchitis ☐ Asthma
☐ Emphysema ☐ Shortness of Breath
☐ Sleep Apnea ☐ (CPAP) ☐ Thyroid Disease
☐ Dialysis ☐ Adrenal Gland Problems
☐ Kidney Disease ☐ Kidney Stones
☐ Liver Disease ☐ Hepatitis type_____
☐ Cirrhosis ☐ Jaundice ☐ Hiatal Hernia
☐ Ulcers ☐ GERD ☐ Strokes ☐ Seizures ☐ TIA
☐ Fainting Episodes ☐ Dizziness ☐ Paralysis
☐ Back or Neck Injuries ☐ Muscle Disease
☐ Parkinson's ☐ Fibromyalgia ☐ Muscle Spasm
☐ Depression ☐ Anxiety Reactions ☐ Psychiatric Care
☐ Arthritis ☐ Glaucoma ☐ False Eye Prosthesis
☐ Hearing Disability ☐ Phlebitis ☐ Blood Clots
☐ Anemia ☐ Organ Transplant Type_____
☐ Other:_____
_____
_____
_____

Vital Signs: (Nurse will do on the day of procedure)
BP_____ PO2_____ HR_____

Please fill out our Medication Reconciliation Form

Simi Surgery Center
1920 E Los Angeles Ave
Simi Valley, CA 93065
805/306-8800 (Fax 306-3309)

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