EAST TENNESSEE AMBULATORY SURGERY CENTER, LLC
701 MED TECH PARKWAY
JOHNSON CITY, TN 37604
PH. (423) 283-7302 FAX (423) 282-3670

PATIENT LABEL

ANESTHESIA PREOPERATIVE QUESTIONNAIRE

SURGERY DATE:	SURGEON:	PROCEDURE:

PATIENT NAME:	AGE:	☐ Male ☐ Female	Height: Weight:

LIST ALL PREVIOUS SURGERIES OR PROCEDURES REQUIRING SEDATION with dates:

Previous Anesthesia Problems or Complications: (For you or any blood relative)

- ☐ Never had anesthesia
- ☐ No problems with anesthesia
- ☐ Difficult Airway/Breathing
- ☐ Prolonged Weakness
- ☐ Prolonged hospital stay
- ☐ Difficulty awakening after procedure
- ☐ Nausea and/or Vomiting
- ☐ High fever
- ☐ Malignant Hyperthermia
- ☐ Other:

FOR CHILDREN under age 18:

☐YES ☐NO	Premature Birth	☐YES ☐NO	Respiratory illness in past month
☐YES ☐NO	Breathing problems after birth	☐YES ☐NO	Family history of muscle disease
☐YES ☐NO	Heart problems after birth	☐YES ☐NO	Other conditions being treated for:

For All Patients:

HEART		*STOMACH*	
☐YES ☐NO	High Blood Pressure	☐YES ☐NO	Gastric Reflux/ GERD
☐YES ☐NO	Heart Attack, When:	☐YES ☐NO	Hiatal Hernia
☐YES ☐NO	Heart Surgery, When:	☐YES ☐NO	Frequent Heartburn
	Type:	☐YES ☐NO	Lap Band, Year:
☐YES ☐NO	EKG, When:		
	Where:	*GLANDS*	
☐YES ☐NO	Pacemaker/Internal Defibrillator	☐YES ☐NO	Diabetes Avg. Morning Blood Sugar:
☐YES ☐NO	Congestive Heart Failure	☐YES ☐NO	Glucose Intolerance
☐YES ☐NO	Angina/Chest Pain	☐YES ☐NO	Hypoglycemia/Low Blood Sugar
☐YES ☐NO	Elevated Cholesterol	☐YES ☐NO	Thyroid Disorder
☐YES ☐NO	Irregular Heart Beat or Murmur	☐YES ☐NO	Jaundice
☐YES ☐NO	Heart Valve Disease, Type:		
BREATHING/RESPIRATORY		*MUSCLES AND BONES*	
☐YES ☐NO	Shortness of Breath	☐YES ☐NO	Arthritis requiring treatment
☐YES ☐NO	Asthma or Wheezing	☐YES ☐NO	Problems opening mouth/ TMJ
☐YES ☐NO	Emphysema / COPD	☐YES ☐NO	Back or Neck Problems
☐YES ☐NO	Lung Disease, Type:	☐YES ☐NO	Back or Neck Surgery
☐YES ☐NO	Chronic Bronchitis	☐YES ☐NO	Numbness or weakness of muscles
☐YES ☐NO	Snore, or been told you stop breathing while	☐YES ☐NO	Chronic pain, Location:
	you sleep?	*BRAIN*	
☐YES ☐NO	Sleep Apnea	☐YES ☐NO	Seizures, Type:
☐YES ☐NO	Frequent morning headaches or fall asleep		Date of Last Seizure:
	during the day?	☐YES ☐NO	Stroke or Mini Stroke/ TIA, When:
☐YES ☐NO	Use or have CPAP or BiPAP machine	☐YES ☐NO	Fainting Spells
☐YES ☐NO	Smoke, Packs per day:	*KIDNEYS*	
☐YES ☐NO	Smoked in the past? Year quit:	☐YES ☐NO	Kidney Disease
BLOOD SYSTEM		☐YES ☐NO	**Dialysis**
☐YES ☐NO	Blood Clots/ DVT	☐YES ☐NO	Urinary Tract Infections
☐YES ☐NO	Bleeding Disorder, Type:	☐YES ☐NO	Bladder or Kidney Infection within last year?
☐YES ☐NO	Sickle Cell Disease or Trait		When:
☐YES ☐NO	Blood Transfusion, Year:		

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OTHER:

☐YES ☐NO Cancer? If yes, What kind and when: ______

☐YES ☐NO Have a communicable disease? (TB, HIV, AIDS, Venereal Disease, STD's, Hepatitis etc.)
Type: ______

☐YES ☐NO Medi-Port/ Vein Shunt/ Port-A-Cath/ Sub Q port etc.? ______

☐YES ☐NO Prosthetic(s) or implant(s)? Including breasts, joint replacements, etc.______

☐YES ☐NO Body piercing or jewelry? ______

☐YES ☐NO Are you pregnant? □ Yes □ No DATE of last menstrual period: ______

☐YES ☐NO Dentures/ Partials/ Chipped or Loose teeth? Describe:______

☐YES ☐NO Other conditions being treated for?______

☐YES ☐NO Any concerns with your health?______

☐YES ☐NO Have you had any illness or infection requiring ANTIBIOTICS in the past 6 months ? ______

What is the most activity you can do before you get tired or short of breath and have to stop?
☐Walk across the room ☐Walk one block ☐Walk 1 mile ☐Run 1 mile
If 1 block or less, what limits your activity?______

☐YES ☐NO Any other information you feel the anesthesiologist should know?______

MEDICATIONS: Please list the name of all medications that you are taking. *Include* Over the Counter medicines, chronic pain medications, herbs, vitamins, skin patches, eye drops, illegal drugs, oxygen, breathing treatment medications (nebulizer). Please use additional sheet if needed.

Name of Medication	Dosage	Name of Medication	Dosage	Name of	Dosage

LIST ALL ALLERGIES TO MEDICATIONS and REACTION, if known: *LATEX? ☐YES ☐NO*

FORM COMPLETED BY: ______ Relationship to Patient? ______

PATIENT NAME OR PERSON TO CONTACT______

PHONE NUMBER(s) where Nurse or Anesthesiologist may reach you? ( ) ______

********Patient MUST have someone remain at Surgical Center during procedure********