

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

SURGERY DATE:	SURGEON:	PROCEDURE:
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PATIENT NAME:	AGE:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Height: Weight:
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LIST ALL PREVIOUS SURGERIES OR PROCEDURES REQUIRING SEDATION with dates:

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

- | | | |
|---|---|---|
| <input type="checkbox"/> Never had anesthesia | <input type="checkbox"/> Difficult Airway/Breathing | <input type="checkbox"/> Nausea and/or Vomiting |
| <input type="checkbox"/> No problems with anesthesia | <input type="checkbox"/> Prolonged Weakness | <input type="checkbox"/> High fever |
| <input type="checkbox"/> Prolonged hospital stay | <input type="checkbox"/> Malignant Hyperthermia | |
| <input type="checkbox"/> Difficulty awakening after procedure | <input type="checkbox"/> Other: | |

FOR CHILDREN under age 18:

<input type="checkbox"/> YES <input type="checkbox"/> NO Premature Birth	<input type="checkbox"/> YES <input type="checkbox"/> NO Respiratory illness in past month
<input type="checkbox"/> YES <input type="checkbox"/> NO Breathing problems after birth	<input type="checkbox"/> YES <input type="checkbox"/> NO Family history of muscle disease
<input type="checkbox"/> YES <input type="checkbox"/> NO Heart problems after birth	<input type="checkbox"/> YES <input type="checkbox"/> NO Other conditions being treated for:

For All Patients:

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

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*******