Patient Name: _____ Primary care physician/phone number: _____

What is your Age? _____ Height? _____ Weight? _____ lbs.

Please list any allergies and the types of reactions:

Allergy	Reaction	Allergy	Reaction

Please list your current medications, including herbal supplements, vitamins and diet pills:

Medication	Dosage	How often	Medication	Dosage	How often

Please list your previous surgeries/procedures and any complications:

Approx Date	Procedure	Complications	Approx Date	Procedure	Complications

Medical History: Have you EVER had any of the following?

***Indicates need for additional information**

Yes	No	**Heart or Vascular Problems**
○	○	High blood pressure or hypertension?
○	○	High cholesterol or hyperlipidemia?
○	○	Do you get chest pain or shortness of breath when you climb a flight of stairs or walk up a hill?
○	○	Coronary artery disease, angina (chest pain), heart attack, angioplasty (balloon), cardiac stent?
○	○	*Abnormal* stress test, heart catheterization, echocardiogram (echo), or electrocardiogram (EKG)?
○	○	Congestive heart failure (CHF/Fluid in the lungs)?
○	○	Cardiac arrhythmia or irregular heart beat (atrial fibrillation)?
○	○	Pacemaker? *If Yes, please complete Pacemaker-ICD Form (Page 3 of this Questionnaire).*
○	○	ICD (implantable cardioverter defibrillator)? *If Yes, please complete Pacemaker-ICD Form.*
○	○	Severe disease of the aortic or mitral heart valves (aortic/mitral stenosis, aortic/mitral insufficiency)?
○	○	Peripheral vascular disease?

Yes	No	
		Respiratory or Breathing Problems
○	○	Have you ever smoked? Packs per day? _____ How many years? _____ When did you quit? _____
○	○	"Wheezing", COPD (Emphysema, chronic bronchitis) or Asthma?
○	○	Do you use oxygen at home?
○	○	Have you visited the emergency room for breathing problems in the past 2 years?
○	○	Upper respiratory infection or new productive cough within the past week?
○	○	Sleep apnea? If so, do you use CPAP to sleep? Yes_____ No_____
		Neurologic Problems
○	○	Stroke (CVA) or mini-stroke (TIA)? If yes, when? _____
○	○	Seizures or epilepsy? If yes, when was your last seizure? _____
○	○	Neck pain and/or back pain?
○	○	Peripheral neuropathy (numbness or tingling in hands, arms, feet, or legs)?
		Endocrine or Metabolic Problems
○	○	Diabetes?
○	○	Thyroid Disease?
○	○	Have you taken steroids *within the last year* to treat breathing problems or arthritis?
		Gastrointestinal or Liver Problems
○	○	Inflammatory bowel disease (Crohn's or Ulcerative colitis)?
○	○	Hiatal hernia, GERD (gastroesophageal reflux disease) or peptic ulcer disease?
○	○	Cirrhosis of the liver?
○	○	Hepatitis B or C?
		Kidney Problems
○	○	Kidney failure requiring dialysis? If yes, what days of the week do you receive dialysis? _____
		Blood Problems
○	○	Anemia (low red blood cells)?
○	○	Thrombocytopenia (low platelet count)?
○	○	Blood clotting problems or excessive bleeding (Hemophilia, von Willebrands's disease)?
○	○	Sickle cell disease or trait?
○	○	Deep venous thrombosis (DVT) or pulmonary embolism (PE)?
○	○	Do you take any blood thinners (anticoagulants)?
○	○	HIV/AIDS?
		Anesthesia Problems
○	○	Do you have a personal or family history of malignant hyperthermia or porphyria?
○	○	Told that it was difficult to place a breathing tube in your airway (intubation)?
○	○	Had severe nausea/vomiting or other sever reaction after anesthesia?
		Other
○	○	Cancer? If yes, what kind? _____ (*Head/Neck) Chemotherapy or radiation? If yes, when? _____
○	○	Do you refuse to receive a blood transfusion if medical necessary?
○	○	Rheumatoid arthritis, Lupus or other autoimmune disease?
○	○	Is there a possibility you may be pregnant? Date of last menstrual period _____
○	○	Do you drink alcoholic beverages? Average number of drinks per week _____
○	○	Is there anything else about your medical history not mentioned above? If yes, please describe:

_____

_____

_____ _____ _____

Signature of Patient or Guardian Date Time

Westside Regional Medical Center ▼ **Patient Identification/Label** ▼

PRE-ANESTHESIA PATIENT QUESTIONNAIRE