

ANESTHESIA QUESTIONNAIRE

US Naval Hospital, Bremerton - Department of Anesthesia

Day of Surgery: _____

Please complete the following questionnaire. Accurate completion of this form will assist your anesthesia provider in formulating an appropriate anesthetic plan for your surgical procedure. Please make special note of the **BOLD** headings. Thank you.

Name		Age	Height	Weight	Contact Number
Planned Surgical Procedure			Any ALLERGIES to Medications, Foods, or Latex?		
			Type of Reaction		
PREVIOUS SURGERIES					
Date (Approximate)	Procedure / Surgery Type (If not sure, what part of body)	Type of Anesthesia (General / Spinal)	Any problems with your anesthesia or your surgery?		

Family history of problems with anesthesia? YES NO If yes, what type: _____

Are you a **SMOKER** or have you ever smoked? YES NO How many _____ packs/day for _____ years

Have you quit smoking? YES NO When? _____

Do you drink **ALCOHOL**? YES NO Average number or drinks per week: _____

Have you had a **COUGH or COLD** in the last 2 weeks? YES NO Symptoms: _____

What **MEDICATIONS** do you take regularly? (Include prescriptions, over the counter medications & herbal supplements)
Note – if you have **High Blood Pressure** or **Diabetes**, please be specific about the medications that you take for these health problems as we may have specific instructions about what medications to take or not take pre-operatively.

In the last 12 months have you taken steroid medication (Prednisone, Hydrocortisone, ACTH, etc.)? YES NO

How often do you exercise: Daily 2-3 times per week Never

Type of exercise: _____

Do you experience any chest pain, shortness of breath, or other concerning symptoms while you exercise? YES NO
If yes, please describe: _____

*Please complete the upper portion on the **BACK** of this form as it relates to a review of body systems and any health conditions that you may have which could impact your anesthetic care.

Place label here

Medical History - Do you have or have you ever had a problem with the following? Please circle your response.					
Your Heart or Blood Vessels			Other Body Systems / Diseases		
X / A	Heart Attack / Chest Pain	Yes No	X / A	Diabetes – Insulin or Oral medication	Yes No
X	High Blood Pressure	Yes No		Thyroid Problems	Yes No
X	Stroke / Peripheral Vascular Disease	Yes No		Gastrointestinal / Reflux or Heartburn	Yes No
X	Pacemaker / Irregular heart beat / Murmur	Yes No	X	Kidney or Liver Disease	Yes No
X	High Cholesterol	Yes No		Bleeding abnormalities / Anemia	Yes No
X	Hospitalization for heart problem	Yes No	Other Health Information		
X / A	Chest pain or shortness of breath with exertion / exercise	Yes No		Are you a male older than 45 or a female older than 55	Yes No
	Your LUNGS or Airway		X	Currently smoke tobacco	Yes No
A	COPD / Emphysema / Chronic Bronchitis	Yes No	Please write any additional information you feel is important to make aware to your anesthesia provider:		
A	Asthma / Wheezing (within past year)	Yes No			
A	Sleep Apnea (medically diagnosed)	Yes No			
A	Difficult Intubation w/ previous surgery	Yes No			
Signature of Patient, Parent or Guardian			Pre-Op Consultant		Date

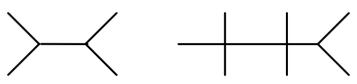
APU STAFF:

* **Pre-op ECG Requirements:** Obtain **ECG** if patient has a history of (1) heart attack or chest pain, (2) chest pain or shortness of breath with exertion/exercise, or (3) if patient's age is > 45 for males or > 55 for females **AND** has 2 or more risk factors for cardiovascular disease denoted with an **X** in the first column. Once ECG obtained, send one copy to Hospitalist with CHCS consult for ECG interpretation, and send patient with other copy of ECG and Outpatient Medical Record to anesthesia for preoperative evaluation.

* Other patients that require pre-operative evaluation are noted above with an **A** in the first column: these patients should be sent to the anesthesia department for further evaluation. All patients ≤ 12 and any patients with questions regarding anesthesia should be directed to the anesthesia department for evaluation and explanation / resolution of their anesthetic questions and concerns.

ANESTHESIA STAFF TO COMPLETE ANESTHESIA PRE-OP ASSESSMENT SECTION BELOW

Review of Medical History and Health Problem List		Vital Signs	Study
		BP	EKG
		P	
		RR	CXR
		Temp	
		SpO2	

Laboratory Findings	HCG	ASA Status	Physical	AIRWAY
	NEG POS N/A	1 2 3 4 5 E NPO _____	Heart Lungs	MP Dentition ROM/TMD

<p>The patient verbalizes understanding of the information that was presented to them. Barriers to learning: None Physical Emotional Cognitive</p> <p>Patient identity confirmed. NPO Status verified. Patient evaluated and records reviewed without contraindication to proceed with anesthetic for planned surgery. Informed consent obtained on separate form.</p> <p>Anesthetic Plan:</p>	Other information		
	Signature	Date	Time