

Modern anesthesia is very safe, but like any medical procedure, there are risks. Major problems, even death or major disability, can occur even in the best situations; however, these are very rare. Before surgery, you will be interviewed by an Anesthesiology Provider and at that time, the risks and benefits of the types of anesthesia will be fully discussed with you and a final choice of anesthetic will be made. Please feel free to ask questions about your anesthesia care.

Please **complete** and **sign** the following questionnaire. This will be reviewed by the Anesthesia Staff and will be very helpful in determining the most appropriate anesthetic for you.

NAME	AGE	HEIGHT ft in	WEIGHT lbs.	OCCUPATION	TELEPHONE NUMBER
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PLANNED SURGICAL PROCEDURE	Any Allergies? If yes, please list what you are allergic to and the type of reaction.
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PREVIOUS SURGERIES & ANESTHESIA			
Date	Procedure	Anesthesia (General, Spinal, Epidural, etc.)	Problems, if any?

Has anyone in your family had problems with anesthesia? _____

Is there any possibility that you are or might become pregnant? Yes No Not Applicable

Have you ever had a blood transfusion? Yes No Unknown Any reactions? _____

Have you had cold symptoms (cough, runny nose, fever) in the past 2 weeks? _____

Do you or have you ever smoked tobacco? Yes No How many packs/day? _____ Years? _____ Quit? _____

Physical Activity: Limited Moderate Very Active Type of Exercise: _____

Have you taken steroids in the past 6 months? Yes No (example: Prednisone, Cortisone, etc.)

Please list what medication and when taken: _____

In the past 2 weeks, have you taken Aspirin, ibuprofen (Advil[®], Motrin[®]), Plavix[®] or Coumadin (Warfarin[®])? Yes No

Please list what medication and when taken: _____

What medications, vitamins and/or herbal supplements do you take regularly? (List dose if known / Attach additional list as necessary)

Have you ever had the following?

Heart Disease / Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding Tendency / Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pain <input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia (low blood counts) <input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Reflux / Heartburn <input type="checkbox"/> Yes <input type="checkbox"/> No	Head Injury <input type="checkbox"/> Yes <input type="checkbox"/> No
Pacemaker or Defibrillator <input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach or Intestinal Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis / Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma / Wheezing <input type="checkbox"/> Yes <input type="checkbox"/> No	Alcohol or Drug Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No	Mental Illness <input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis / Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Medical Problems: _____
Lung Disease / Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	
Sleep Apnea (OSA) <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	
CPAP/BiPAP machine? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Patient Signature (or Parent/Legal Guardian) _____ **Date** _____

ADDRESSOGRAPH

To be completed by Anesthesia Provider

Suitable for Surgery Yes No Pending

Reason: _____

Evaluator Signature _____ **Date/Time** _____