PRE-ANESTHESIA EVALUATION

INSTRUCTIONS TO THE PATIENT – The intention of this questionnaire is to help your anesthetist select the proper anesthesia technique for you.

Name Today's date

General Health	Excellent ❑ Good ❑ Fair ❑ Poor ❑	Height	Weight	Age	Sex

Has anyone in your family: had a tendency to bleed excessively? YES ❑ NO ❑
had unexplained fevers during anesthesia? YES ❑ NO ❑
had any unusual reactions to anesthesia? YES ❑ NO ❑

YES	NO	YOUR MEDICAL HISTORY	CHECK BOXES
		Do you smoke?	Have you had surgery on the
		Do you drink alcoholic beverages?	❑ Jaw ❑ Kidney ❑ Abdomen
		Have you had a blood transfusion?	❑ Thyroid ❑ Breast ❑ Lung
		Are you pregnant at this time?	❑ Heart ❑ Brain ❑ Neck
		Are you allergic to any medications?	Other:
		If yes, what?	

YES	NO	HAVE YOU EVER HAD…?	YES	NO	
		Heart Disease? Heart Failure? Heart Attack?			Thyroid Disease?
		Heart Murmur? Rheumatic Fever?			Diabetes Mellitus?
		High Blood Pressure?			Frequent Indigestion? Hiatal Hernia?
		Palpitations? (irregular or extra heart beats)			Easy Bruising or Bleeding Excessively?
		Chest Pain or Angina?			Blood Disorders?
		Abnormal EKG?			Ulcers? Obstructions?
		Stroke?			Glaucoma?
		Abnormal Shortness of Breath?			Frequent Headaches?
		Asthma or Wheezing?			Nerve Paralysis?
		Emphysema?			Fainting Spells?
		Bronchitis? Pneumonia?			Epilepsy? (seizures)
		Tuberculosis?			Back Pain/Back Problems? Arthritis?
		Smoker's Cough?			Phlebitis?
		Hay Fever?			Nervous or Psychiatric Disorder?
		Hepatitis? Liver Disease?			Drug Addiction or Alcoholism?
		Gallbladder Disease?			Serious Illness During Pregnancy?
		Kidney Disease?			Motion Sickness?
		Sickle Cell Anemia?			Other Illness Not Mentioned?
YES	**NO**	**DO YOU?**	**YES**	**NO**	**DO YOU?**
		Wear removable dentures?			Have a false eye?
		Contact Lenses?			Have any teeth loose or chipped?
		False eyelashes?			Any major physical or congenital defects?
		Have porcelain caps on your teeth?			Have difficulty opening your mouth?
		Have difficulty w/movement of your head?			Have cataracts?
YES	**NO**	**WHAT KIND OF ANESTHESIA HAVE YOU HAD BEFORE?**			
		Saddle/Spinal "Block"/Epidural			Local or nerve blocks?
		General (Completely asleep?)			Have you had any unusual reactions?
		Pentothal?			Problems or complications with anesthesia?

MEDICATIONS: Please list names and doses of any medicines you take now or have taken within the last 6 months.

SIGNATURE: **DATE:**