

# Anesthesiology Pre-Operative Health Questionnaire<sup>1.5</sup>

Completed on \_\_\_ / \_\_\_ / 2010

Name: \_\_\_\_\_ Date of Birth: \_\_\_ / \_\_\_ / \_\_\_\_\_

Proposed Surgery \_\_\_\_\_

To Treat (Condition) \_\_\_\_\_

## **Cardiac** (Questions about Your Heart)

- Have You ever visited a Heart Doctor (Cardiologist)  Never | Date \_\_\_ / \_\_\_ / \_\_\_\_\_
- Have You ever had an EKG (Heart Tracing) done  Never | Date \_\_\_ / \_\_\_ / \_\_\_\_\_
- Have You ever had a Stress Test (exercise heart tracing) done  Never | Date \_\_\_ / \_\_\_ / \_\_\_\_\_
- Have You ever had a Cardiac Echo (heart pictures) done  Never | Date \_\_\_ / \_\_\_ / \_\_\_\_\_
- Have You ever had a Cardiac Catheterization (through groin)  Never | Date \_\_\_ / \_\_\_ / \_\_\_\_\_

*Has any doctor told You that you have (check those that apply)*

- High Blood Pressure
- Murmur or Valve Problems
- Irregular Heartbeat (Palpitations)
- Coronary Artery Disease (Blockages)
- Heart Attack (MI/Myocardial Infarction)
- Heart Failure (CHF)

*Do you get (circle the appropriate answer)*

- Breathless            Never | Heavy exercise | Light exercise | Any Activity | At Rest | At Night
- Chest Pain            Never | Heavy exercise | Light exercise | Any Activity | At Rest
- Arm Numbness        Never | Heavy exercise | Light exercise | Any Activity | At Rest | At Night

## **Exercise Tolerance**

*Do you get Chest Pain/Arm Numbness/ Breathlessness when you are*

- At rest
- Walking to bathroom
- Putting on my clothes
- Walking around the house without resting
- Doing light house cleaning without resting
- Vacuuming the house without resting
- Walking briskly one block on flat surface
- Playing golf
- Yard / Ranch work
- Jogging/running a short distance
- Riding a bicycle
- Playing Tennis
- Playing Football/Soccer/Basketball

Please underline above the level of physical stress or exercise that you have had in the past month

## **Pulmonary** (Questions about your Lungs)

Have You ever visited a Lung Doctor (Pulmonologist) ?  Never | Date \_\_\_ / \_\_\_ / \_\_\_\_\_

*Has any doctor told You that you have or have you had (check those that apply)*

- Emphysema/COPD/Chronic Bronchitis
- Tuberculosis

*Have you had in the past or have now?*

- Recent Cold / Flu
- Asthma / Shortness of breath
- Respiratory Failure
- Long-standing Cough

**Central Nervous System** (Questions about your Brain)Have You ever visited a Brain Doctor (Neurologist) ?  Never | Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_*Has any doctor told You that you have (check those that apply)*

- |  |                                     |
|--|-------------------------------------|
| <input type="checkbox"/> Seizures                              | <input type="checkbox"/> Bipolar    |
| <input type="checkbox"/> Strokes (including “mini Stroke/TIA”) | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Dementia                              | <input type="checkbox"/> Anxiety    |
| <input type="checkbox"/> Cerebral Palsy                        | <input type="checkbox"/> Psychosis  |
| <input type="checkbox"/> Syncope (passing out)                 |                                     |

**Endocrine** (Questions about your Glands)Have You ever visited an Endocrinologist ?  Never | Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_*Has any doctor told You that you have (check those that apply)*

- |                                   |  |
|-----------------------------------|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Adrenal Disease |
| <input type="checkbox"/> Thyroid  |  |

**Renal** (Questions about your Kidneys)Have You ever visited a Kidney Doctor (Nephrologist)?  Never | Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_*Has any doctor told You that you have or have you had (check those that apply)*

- |   |  |
|---|--|
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Renal Artery Stenosis |
| <input type="checkbox"/> Dialysis       |  |

**Gastrointestinal** (Questions about your Stomach)Have You ever visited a Stomach Doctor (Gastroenterologist)?  Never | Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_*Has any doctor told You that you have or have you had (check those that apply)*

- |   |  |
|---|--|
| <input type="checkbox"/> Vomiting/Nausea    | <input type="checkbox"/> Gastroparesis |
| <input type="checkbox"/> Reflux (Heartburn) | <input type="checkbox"/> Ulcers        |
| <input type="checkbox"/> Hiatal Hernia      |  |

**Hepatic** (Questions about your Liver)Have You ever visited a Liver Doctor (Hepatologist)?  Never | Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_*Has any doctor told You that you have or have you had (check those that apply)*

- |  |                                       |
|--|---------------------------------------|
| <input type="checkbox"/> Hepatitis     | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Cirrhosis     | <input type="checkbox"/> Jaundice     |
| <input type="checkbox"/> Liver Failure |                                       |

**Musculoskeletal** (Questions about your Bones and Muscles)

Has any doctor told You that you have or have you had (check those that apply)

- Neck Pain
- Low Back Pain
- Muscle Spasms
- Paralysis
- Spasticity (Stiff Arm/Leg)
- Kyphosis/Scoliosis (Spine bent the wrong way)

**OB** (Questions about your Pregnancy and Baby)

Last Menses \_\_\_ / \_\_\_ / 201

Have You ever visited a Pregnancy Doctor (Obstetrician)?

Never | Date \_\_\_ / \_\_\_ / \_\_\_

- Currently Pregnant - \_\_\_ wks,
- Healthy Baby (Fetus)
- First Pregnancy
- Pre/Eclamsia
- Cesarean Section in the Past

**Anesthesia Problems in Past**

- vomiting/nausea
- slow wakeup
- seizure
- blood relatives with problems during Anesthesia – problems: \_\_\_\_\_
- high fever
- difficult intubation
- embolus/blood clots
- have never had general anesthesia
- heart attack
- irregular heartbeat
- recall (memory of surgery)
- stroke
- death

**Pediatric** (Questions about to your Child which is having surgery)

does not apply

- Birth Uneventful
- Lung Problems
- Recent Colds
- Runny Nose
- Meconium
- Keeps up with Friends
- Keeps up with Milestones
- Went home with mom after delivery
- Breathing Machine (ventilator) after birth

**Vices**

- Smoking
- Drinking
- Street Drugs

**Food or Drink**

Last time ate or drank anything (no food 8 hrs before surgery) \_\_\_ : \_\_\_ AM | PM

**Allergies**

None (NKDA) | \_\_\_\_\_

**Medications**

(Please list all the medications that were prescribed to you)

- Taking as prescribed | \_\_\_\_\_
- Taking as prescribed | \_\_\_\_\_
- Taking as prescribed | \_\_\_\_\_
- Taking as prescribed | \_\_\_\_\_
- Taking as prescribed | \_\_\_\_\_
- Taking as prescribed | \_\_\_\_\_
- Taking as prescribed | \_\_\_\_\_
- Taking as prescribed | \_\_\_\_\_
- Taking as prescribed | \_\_\_\_\_
- Taking as prescribed | \_\_\_\_\_
- I have More Prescribed Medications (Please attach a list)