



PRE-ANESTHESIA QUESTIONNAIRE

Name	Age	Height
Physician/Surgeon		

Do you, or have you had, any of the following medical conditions?

Please Mark All Boxes	YES	NO	Please List Any Allergies to Medications and/or Food
Allergies of Any Type			
Recent Cold/Flu			
Asthma/COPD			
Pneumonia/TB			
Chronic Cough			
Emphysema			
Other Lung Trouble			
Nighttime Snoring			
Sleep Apnea			
Smoking			
Rheumatic Fever			
Heart Murmur			
High Blood Pressure			Please List All Medications and/or Supplements
Low Blood Pressure			
Chest Pain/Angina			Dose
Heart Attack/MI			Frequency
Irregular Heart Beat			
Palpitations			
Shortness of Breath			
How far can you walk without being short of breath? 1 2 3 or more blocks			
Pacemaker/AICD (Defib)			Please List Any Previous Surgeries
Angioplasty or Stent			
Bleeding or Easy Bruising			
Jaundice/Hepatitis			
Acid Reflux/GERD			
Back Pain/Sciatica			
Neck Pain			
Arthritis			
Weakness/Numbness in Arms or Legs			
Disabling accident or Fall			Any Other Comments
Epilepsy/Convulsions			
Stroke/CVA			
Paralysis/Polio			
Thyroid Disease			
Diabetes			
Kidney Disease			
Drink Alcoholic Beverages			
Recreational Drugs			
Blood Transfusions			
Denture/Caps/Loose Teeth			
Other Dental Devices			
Dental Bonding/Laminates			Internist/Family Doctor Name
Motion Sickness			Anesthesiologist Signature
Could You be Pregnant			Date
Last Menstrual Period Date			
Unusual Reaction to Anesthesia in Past			Patient Signature
			Date