REGIONAL ANESTHESIA GROUP

Pre-Anesthesia Questionnaire

Please take a moment to answer the following questions which are important for your plan of care before, during and after your surgery.

Patient name: _____

Date: _____ Age: _____ Weight: _____ Height: _____

Allergies: _____

_____

Prior operations: _____

_____

Yes	No	Questions
☐	☐	Have you recently had a cold or the flu?
☐	☐	Are you allergic to latex or rubber products?
☐	☐	Have you experienced chest pain?
☐	☐	Do you have a heart condition?
☐	☐	Do you have hypertension (high blood pressure)?
☐	☐	Do you experience shortness of breath?
☐	☐	Do you have asthma, bronchitis or any other breathing problem?
☐	☐	Do you (or did you) smoke? ___ Packs/day ____ Number of Years_____ Date you quit
☐	☐	Do you consume alcohol? ____ Drinks per week
☐	☐	Do you take or have you taken recreational drugs?
☐	☐	Have you taken cortisone (steroids) in the last six months?
☐	☐	Do you have diabetes?
☐	☐	Have you had hepatitis, liver disease or jaundice?
☐	☐	Do you have a thyroid condition?
☐	☐	Do you have or have you had kidney disease?
☐	☐	Do you have ulcers or other stomach disorders?
☐	☐	Do you have a hiatal hernia?
☐	☐	Do you have back or neck pain?
☐	☐	Do you have numbness, weakness or paralysis of your extremities?
☐	☐	Do you have muscle or nerve disease?
☐	☐	Do you or any of your family have sickle cell trait?
☐	☐	Have you or any of your blood relatives had difficulty with anesthesia?
☐	☐	Do you have bleeding problems, or are you taking blood thinners?
☐	☐	Do you have loose, chipped or false teeth, or bridge work?
☐	☐	Do you have any oral piercings (such as stud or rings) in your tongue or lip (Please remove prior to surgery)?
☐	☐	Do you wear contact lenses (Please remove prior to surgery)?
☐	☐	Have you ever received a blood transfusion?
☐	☐	(Women) Are you pregnant? Due date: _____

Please be sure to complete the Personal Medication List or bring in your medications in their original bottlees for the Pre-Op Clinic Nurse to review.