

**BLOOMINGTON / NORMAL HEALTHCARE**

**SURGERY CENTER**

**PRE-ANESTHESIA/ SURGERY QUESTIONNAIRE**

Date of Surgery: \_\_\_\_\_

Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Actual Weight: \_\_\_\_\_

Surgeon: \_\_\_\_\_

Age: \_\_\_\_\_

Height: \_\_\_\_\_

1. Allergies (Include medications, foods, environment, balloons, and/or latex allergies). Name and describe reactions.

If no allergies, check here.

2. Any Previous Surgeries (List type and year). \_\_\_\_\_

Have you ever had a problem with an anesthetic? \_\_\_\_\_

Yes

No

If yes, what happened? \_\_\_\_\_

Has anyone in your family ever had a problem with an anesthetic? \_\_\_\_\_

Yes

No

If yes, what happened? \_\_\_\_\_

3. Have you had within the last month, any of the following?

	Yes	No
Cold	<input type="checkbox"/>	<input type="checkbox"/>
Flu	<input type="checkbox"/>	<input type="checkbox"/>
Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>
Congested Cough	<input type="checkbox"/>	<input type="checkbox"/>
Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Injury	<input type="checkbox"/>	<input type="checkbox"/>

If yes, explain: \_\_\_\_\_

4. Do you use tobacco? Yes  No

Quit  When? \_\_\_\_\_

What? \_\_\_\_\_

Packs per day? \_\_\_\_\_

How many years? \_\_\_\_\_

Do you drink alcohol? Yes  No

If yes, amount per day? \_\_\_\_\_

Week? \_\_\_\_\_

Month? \_\_\_\_\_

Do you use street drugs? Yes  No

If yes, drug name: \_\_\_\_\_

Last used: \_\_\_\_\_

5. Check any of the following that you have:

Glasses  Contact Lens  Hearing aid: L  R

Dentures: Upper  Lower  Capped Teeth  Partial / Bridge: Upper  Lower

Walker  Cane  Crutches  Wheelchair

Prosthesis:  \_\_\_\_\_

Implants:  \_\_\_\_\_

6. Are there any religious or cultural practices that the staff needs to be aware of while here?

Yes

No

If yes, list: \_\_\_\_\_

7. Do you follow a certain diet at home? Yes  No

If yes, please explain: \_\_\_\_\_

8. Answer if patient is 16 or under:

Is there any developmental delay? Yes  No  If yes, explain: \_\_\_\_\_

Childhood immunizations up to date? Yes  No  If no, explain: \_\_\_\_\_

Was child born on at: Full term  Premature by: \_\_\_\_\_ weeks

Please complete other side

9. Do you have a medical history of (please check in appropriate column):

	Yes	No	Comments		Yes	No	Comments
Heart Attack (Date)				Bowel Problems			
Mitral Valve Prolapse/Murmur				Arthritis			
Irregular Heart Beat				Back Problems/Back Pain			
Fast Heart Rate				Meningitis			
Congestive Heart Failure				Cerebral Palsy			
High Blood Pressure				Multiple Sclerosis			
Rheumatic Fever				Seizure Disorder/Epilepsy			
Pacemaker				Motion Sickness			
Pain in Chest/Arm/Shoulder				Headache			
Shortness of Breath				Parkinson's			
Asthma				Stroke (Date)			
Emphysema				Myasthenia Gravis			
Bronchitis				Depression			
Hay Fever				Anxiety			
Tuberculosis				Mental Disorder			
Chronic Cough				Bleeding Disorder			
Ulcers				Diabetes			
Liver Disease				Glaucoma			
Jaundice/Hepatitis				Thyroid Problem (Low/High)			
Hiatal Hernia				AIDS/HIV			
Kidney Disease				Cancer (Type)			
Kidney Stone				Treatment:			
Dialysis				Carrier Infectious Disease			
Frequent Urination				Are you pregnant?			
Incontinence				Last Menstrual Period: Date:			
Prostate Problems				Mental or Physical Handicaps:			

10. Medications: List all medications currently taking below: (Include prescription, non-prescription drugs, and herbals)

If taking no medications, check here  \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

**Surgecenter Use Only Below**

Surgical Procedure: \_\_\_\_\_ Date: \_\_\_\_\_ Reviewed by: \_\_\_\_\_  
 Pre-op Phone Call: No Health Changes  \_\_\_\_\_ RN Signature \_\_\_\_\_ Date \_\_\_\_\_  
 \_\_\_\_\_ Reviewing Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Anesthesia Notes:**

Airway: \_\_\_\_\_  
 Heart:  WNL  Other \_\_\_\_\_  
 Lungs:  Clear to Auscultation  Other \_\_\_\_\_  
 EKG:  WNL  Other \_\_\_\_\_  
 CXR:  WNL  Other \_\_\_\_\_  
 Labs: \_\_\_\_\_

Anesthesia Type:  General  Regional  MAC  Local  
 ASA Physical Status 1 2 3 4 5 E

Physician's Signature \_\_\_\_\_ Date (Day of Surgery) \_\_\_\_\_