Unity SURGICAL CENTER Pre-Anesthesia Questionnaire

DO YOU HAVE OR HAVE HAD THE FOLLOWING?	NO	YES	WHEN/COMMENTS	DO YOU HAVE OR HAVE YOU HAD THE FOLLOWING?	NO	YES	WHEN/ COMMENTS
A cold, sore throat, flu in the last 6 weeks?				Diabetes Type:_____			Do you take insulin? ☐ Yes ☐ No
Asthma				Hypoglycemia (Low Blood Sugar)			
Emphysema, Chronic Bronchitis				Thyroid Disease			
Shortness of Breath				Hepatitis, Jaundice, Liver Disease			
Any Other Lung Problems				Acid Reflux, Heartburn, Ulcers			
Do You Smoke?			Packs/day_____	Kidney Problems / Prostate Problems			
Past Smoker?			When Quit _____ _____pk/day	Glaucoma			
Sleep Apnea (Obstruction)			☐ CPAP ☐ BIPAP	Cancer			
Heart Attack or Congestive Heart Failure				Radiation, Chemotherapy			
Chest Pain or Angina or Heart Surgery or Balloon/Stent				Have You Had Surgery/Anesthesia Before?			General? ☐ Block? ☐
Heart Murmur				Have You Had Any Problems With Anestheisa? (High Temp, Weakness, Difficult Airway / Intubation, etc)			
Irregular Heart or Palpitations				Have Any Blood Relatives Had An Unusual Reaction to Anesthesia?			
Pacemaker or Defibrillator				TMJ or Difficulty Opening Mouth			
High Cholesterol				Dentures, Caps, Loose Teeth			
High Blood Pressure				Motion Sickness			
Low Blood Pressure				Have You Taken Any Addicting or Recreational Drugs?			
Vascular (Blood Vessel) Disease				Do You Drink Alcohol?			☐ Rarely ☐ Daily ☐ Weekly
TIA or Stroke				Have You Taken Diet Pills or Sex Enhancing Medications In The Past Week?			Which Medications? _____ _____ When_____ _____ _____
Arthritis			Type_____	Open Wounds, Rashes or Lesions			
Anemia				Do You Have Allergies Or Sensitivities To Any Medications?			
Bleeding or Blood Clotting Disorders				Do You Have Any Other Allergies? Food - (Bananas, Avocados, Kiwi, Nuts?)			
Nerve / Muscle Dis., Multiple Sclerosis				Who Is Your Primary Doctor?			
Polio, Meningitis, Paralysis				Women:			
Epilepsy or Seizures				Are You Or Could You Be Pregnant?			
Back Pain, Spine Problem, Neck				Last Period			
Restless Leg Syndrome				Have You Given Birth In Last 3 Months?			
Psychiatric or Psychological Problems				Are You Breastfeeding?			

Responsible Caregiver / Driver:_____Phone#:_____will stay with you for following anesthesia or sedation.

ALL PATIENTS/GUARDIANS:
I have read (or had read to me) the foregoing Pre-Anesthesia Questionnaire, and certify that the information provided above is correct to the best of my knowledge.

Signature:_____Date:_____

Printed Name:_____