ROXBURY
SURGERY CENTER

450 NORTH ROXBURY DRIVE
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# PRE-ANESTHESIA/SURGERY QUESTIONNAIRE

1. Name of your regular family doctor ______________________ Phone ______________
   OR ❑ I do not have a regular family doctor
2. Have you ever had any problems with blood pressure, previous heart disease, palpitations or angina? ❑ Yes ❑ No
   If yes, please explain: ______________________
3. Have you had an EKG in the past? ❑ Yes ❑ No If yes, where? when ______________________
4. Any recent exposure to tuberculosis? ❑ Yes ❑ No Any of the following symptoms: night sweats, cough with bloody sputum?
5. Any other medical conditions? List: ______________________
6. Do you have any implants? ❑ Yes ❑ No (Cardiac, Cosmetic, Orthopedic) List: ______________________
7. Do you smoke? ❑ Yes ❑ No How much/day? ______________________
8. Do you drink alcoholic beverages? ❑ Yes ❑ No How much/week? ______________________
9. Do you use recreational drugs? ❑ Yes ❑ No Please list ______________________
10. Are you allergic to anything? ❑ Yes ❑ No List: ______________________
11. Have you ever had motion sickness? ❑ Yes ❑ No
12. Do you have any difficulty opening your mouth? ❑ Yes ❑ No
13. Have you or any blood relative had an unusual reaction to anesthesia or malignant hyperthermia? ❑ Yes ❑ No
14. Do you currently take any medications ? ❑ Yes ❑ No
15. Within the last year have you had cortisone or steroids? ❑ Yes ❑ No
16. Do you have bleeding tendencies? ❑ Yes ❑ No
17. Have you taken any medication today? ❑ Yes ❑ No List: ______________________
18. Do you use aspirin, ibuprophen (Motrin), Advil, Aleve, Naproxen or Anaprox? ❑ Yes ❑ No
    Others ______________________ Last date taken? ______________________
19. Do you use blood thinners (Heparin, Lovenox, Coumadin, etc.)? ❑ Yes ❑ No Last date taken? ______________
20. Could you be pregnant at this time? ❑ Yes ❑ No Date of last menstrual period: ______________
21. Circle pain medications you have ever taken: | Tylenol | Percocet | Codeine | Aspirin | Darvocet | Vicodin | Other
22. Height: ______________ Weight: ______________

## Have you had any of the following:

❑ breathing problems ❑ asthma ❑ hay fever ❑ chronic bronchitis ❑ emphysema ❑ shortness of breath ❑ seizures ❑ convulsions ❑ migraine headaches ❑ fainting spells ❑ stroke ❑ jaundice ❑ hepatitis ❑ liver disease ❑ blood transfusion reactions

## Do you have

❑ diabetes ❑ hypoglycemia ❑ thyroid problems ❑ kidney problems ❑ physical disabilities ❑ back pain ❑ arthritis ❑ bursitis ❑ sleep apnea ❑ C-PAP ❑ Sleeping disorders ❑ Snoring ❑ loose teeth ❑ dentures ❑ contacts ❑ permanent or removable bridges ❑ front capped teeth ❑ latex allergy

## Within the last two weeks have you had any exposure to

❑ a cold ❑ sore throat ❑ flu ❑ chicken pox ❑ mumps ❑ measles (rubeola) ❑ German measles (rubella) ❑ a tranquilizer ❑ diet pills ❑ herbal medications

| Previous Operations | Year Done | Type of Anesthesia (General, Epidural, Spinal, Local) | Complications (i.e. fever, nausea, vomiting, low blood pressure) |
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COMPLETED BY: ______________________

RELATIONSHIP: ______________________ DATE: ______________________

REVIEWED BY: PRE-OP RN: ______________________ OR R.N.: ______________________