ROXBURY
SURGERY CENTER

SUBMIT NOW

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. Have you had any ❑ breathing problems, ❑ asthma, ❑ hay fever, ❑ chronic bronchitis, ❑ emphysema or ❑ shortness of breath?
5. Have you had any ❑ seizures, ❑ convulsions, ❑ migraine headaches, ❑ fainting spells or ❑ stroke?
6. Have you had ❑ jaundice, ❑ hepatitis, ❑ liver disease or ❑ blood transfusion reactions?
7. Do you have ❑ diabetes, ❑ hypoglycemia or ❑ thyroid problems?
8. Do you have kidney problems? ❑ Yes ❑ No
9. Have you had ❑ a cold, ❑ sore throat, or ❑ flu in the last two weeks?
10. Any recent exposure to tuberculosis? ❑ Yes ❑ No Any of the following symptoms: night sweats, cough with bloody sputum?
11. Within the last two weeks have you had any exposure to chicken pox, mumps, measles (rubeola), German measles (rubella)? ❑ Yes ❑ No
12. Do you have any ❑ physical disabilities, ❑ back pain, ❑ arthritis or ❑ bursitis?
13. Do you have sleep apnea? C-PAP? Sleeping disorders? Snoring? ❑ Yes ❑ No
14. Any other medical conditions? List: _____
15. Do you have any implants? ❑ Yes ❑ No (Cardiac, Cosmetic, Orthopedic) List: _____
16. Have you ever had motion sickness? ❑ Yes ❑ No
17. Do you smoke? ❑ Yes ❑ No How much/day? _____
18. Do you drink alcoholic beverages? ❑ Yes ❑ No How much/week? _____
19. Do you use recreational drugs? ❑ Yes ❑ No Please list _____
20. Do you have any ❑ loose teeth, ❑ dentures, ❑ permanent or removable bridges or ❑ front capped teeth?
21. Do you wear contacts? ❑ Yes ❑ No
22. Do you have any difficulty opening your mouth? ❑ Yes ❑ No
23. Have you or any blood relative had an unusual reaction to anesthesia or malignant hyperthermia? ❑ Yes ❑ No
24. Are you allergic to anything? ❑ Yes ❑ No List: _____
25. Do you have a latex allergy? ❑ Yes ❑ No
26. Do you currently take any medications ? ❑ Yes ❑ No
27. Within the last year have you had cortisone or steroids? ❑ Yes ❑ No
28. Within the last two weeks have you taken (Check) ❑ a tranquilizer, ❑ diet pills or ❑ herbal medications? ❑ Yes ❑ No
29. Have you taken any medication today? ❑ Yes ❑ No List: _____
30. Do you use aspirin, ibuprophen (Motrin), Advil, Aleve, Naproxen or Anaprox? ❑ Yes ❑ No
    Others _____ Last date taken? _____
31. Do you use blood thinners (Heparin, Lovenox, Coumadin, etc.)? ❑ Yes ❑ No Last date taken? _____
32. Do you have bleeding tendencies? ❑ Yes ❑ No
33. Could you be pregnant at this time? ❑ Yes ❑ No Date of last menstrual period: _____
34. Circle pain medications you have ever taken: I Tylenol I Percocet I Codeine I Aspirin I Darvocet I Vicodin I Other
35. Height: _____ Weight: _____

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

COMPLETED BY: _____

RELATIONSHIP: _____ DATE: _____

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