# PRE-ANESTHESIA EVALUATION

INSTRUCTIONS TO THE PATIENT – The intention of this questionnaire is to help your anesthetist select the proper anesthetic technique for you.

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<thead>
<tr>
<th>Name</th>
<th>Date</th>
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<tr>
<th>General Health:</th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
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<tr>
<th>Weight</th>
<th>Height</th>
<th>Age</th>
<th>Sex</th>
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Has anyone in your family:  
- had a tendency to bleed excessively?  
- had unexplained fevers during anesthesia?  
- had any unusual reactions to anesthesia?  

Your Medical History:  
- Do you smoke?  
- Do you drink alcoholic beverages?  
- Have you had a blood transfusion?  
- Are you pregnant at this time?  
- Are you allergic to any medications?  

If yes, what?  

Check box(es) if you had surgery on the:  
- BRAIN  
- NECK  
- JAW  
- THYROID  
- LUNG  
- KIDNEY  
- BREAST  
- HEART  
- ABDOMEN  
- __________

HAVE YOU EVER HAD:  
- Heart disease/heart failure/heart attack  
- Thyroid disease  
- Heart murmur/rheumatic fever  
- Diabetes mellitus  
- High blood pressure  
- Frequent indigestion/hiatal hernia  
- Palpitations/irregular heart beats  
- Abdominal ulcers/obstructions  
- Chest pain/angina  
- Easy bruising/excessive bleeding  
- Abnormal EKG  
- Blood disorder  
- Stroke  
- Glaucoma  
- Abnormal shortness of breath  
- Frequent headaches  
- Asthma/wheezing  
- Nerve paralysis  
- Emphysema  
- Fainting spells  
- Bronchitis/pneumonia  
- Epilepsy/seizures  
- Palpitations/irregular heart beats  
- Abdominal ulcers/obstructions  
- Tuberculosis  
- Back pain/problems/arthritis  
- Smoker’s cough  
- Phlebitis/DVT/lung blood clots  
- Hay fever  
- Nervous or psychiatric disorder  
- Hepatitis/liver disease  
- Drug or alcohol addiction  
- Gall bladder disease  
- Serious illness during pregnancy  
- Kidney disease  
- Motion sickness  
- Sickle cell anemia  

DO YOU:  
- Wear removable dentures  
- Have a prosthetic eye  
- Use contact lenses  
- Have a loose or chipped tooth  
- Wear false eyelashes  
- Have difficulty opening mouth  
- Have porcelain caps on teeth  
- Have cataracts  
- Have difficulty moving head/neck  
- Other physical/congenital defect
WHAT KIND OF ANESTHESIA HAVE YOU HAD BEFORE?

- [ ] YES [ ] NO Saddle(spinal)block/epidural
- [ ] YES [ ] NO Local or nerve block
- [ ] YES [ ] NO General anesthetic
- [ ] YES [ ] NO Allergies/unusually reaction
- [ ] YES [ ] NO Pentothal
- [ ] YES [ ] NO Anesthesia complications

**MEDICATIONS:** Please list names and doses of any medicines you take now or have taken within the last six months (or attach list):

<table>
<thead>
<tr>
<th>Current Medication</th>
<th>Dose</th>
<th>Reason for taking medicine</th>
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Taken in last 6 months

<table>
<thead>
<tr>
<th>Current Medication</th>
<th>Dose</th>
<th>Date when discontinued</th>
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DATE: ______________________  ______________________

SIGNATURE OF PATIENT OR GUARDIAN