Newport Beach SURGERY ▪ CENTER

361 Hospital Road, Suite 124 • Newport Beach, CA 92663 • (949) 631-0988

PRE-ANESTHESIA SURGERY QUESTIONNAIRE

Question	YES	NO
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? ________		
If yes, please explain: ________		
3. Have you had an EKG in the past? If yes, where? when ________		
4. Have you had any (Circle) breathing problems, asthma, hay fever, chronic bronchitis, emphysema or shortness of breath? ________		
5. Have you had any (Circle) seizures, convulsions, migraine headaches, fainting spells or stroke? ________		
6. Have you had (Circle) jaundice, hepatitis, liver disease or blood transfusion reactions? ________		
7. Do you have (Circle) diabetes, hypoglycemia or thyroid problems? ________		
8. Do you have kidney problems? ________		
9. Have you had (Circle) 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)? ________		
12. Do you have any (Circle) physical disabilities, back pain, arthritis or bursitis? ________		
13. Do you have sleep apnea? C-PAP? Sleeping disorders? Snoring? ________		
14. Any other medical conditions? List: ________		
15. Do you have any implants? (Cardiac, Cosmetic, Orthopedic) List: ________		
16. Have you ever had motion sickness? ________		
17. Do you smoke? ________ How much/day? ________		
18. Do you drink alcoholic beverages? ________ How much/week? ________		
19. Do you use recreational drugs? ________ Please list ________		
20. Do you have (Circle) any loose teeth, dentures, permanent or removable bridges or front capped teeth? ________		
21. Do you wear contacts? ________		
22. Do you have any difficulty opening your mouth? ________		
23. Have you or any blood relative had an unusual reaction to anesthesia or malignant hyperthermia? ________		
24. Are you **allergic** to anything? List: ________		
25. Do you have a latex allergy? ________		
26. Within the last year have you had cortisone or steroids? ________		
27. Within the last two weeks have you taken (Circle) a tranquilizer, diet pills or herbal medications? ________		
28. Have you taken any medication today? List: ________		
29. Do you use aspirin, ibuprophen (Motrin), Advil, Aleve, Naproxen or Anaprox? ________		
Others ________ Last date taken? ________		
30. Do you use blood thinners (Heparin, Lovenox, Coumadin, etc.)? ________ Last date taken? ________		
31. Do you have bleeding tendencies? ________		
32. Could you be pregnant at this time? ________ Date of last menstrual period: ________		
33. Circle pain medications you have ever taken: ❑ Tylenol ❑ Percocet ❑ Codeine ❑ Aspirin ❑ Darvocet ❑ Vicodin ❑ Other ________		

34. **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/GI R.N.: ________________