Anesthesia Questionnaire

Instructions:

Please answer every question inside this brochure.

Also, please record all of the medications and supplements you take on the Medications Listing.

Remember: You may not have anything to eat or drink after midnight before your surgery and you must have someone to drive you after surgery.

Lucas County Health Center

An Affiliate of UnityPoint Health

Lucas County Health Center
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(641) 774-3374 · (800) 404-3111
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Medications Listing:

Please list all prescriptions and over-the-counter medications, as well as dietary supplements (vitamins & minerals), and herbal supplements. Remember, do not eat or drink anything after midnight prior to your surgery.

Drug Name	Dosage (Amount Taken)	Frequency (How often taken)

Anesthesia Questionnaire

Please take a moment to answer the following questions, which are important for your plan of care before, during, and after your surgery. Please be sure to complete the Personal Medication List or bring in your medications in their original bottles for the pre-operative nurse to review.

Patient Name: _____

Age: _____ Weight: _____ Height: _____ Date: _____

Allergies: ☐ Check here if none or list: _____

Yes No Have you recently have a cold or the flu?
Yes No Are you allergic to latex (rubber) products:
Yes No Have you experienced chest pain?
Yes No Do you have a heart condition?
Yes No Have you had heart surgery (CABG, stents, etc.)? If so, when? _____
Yes No Do you have hypertension (high blood pressure)?
Yes No Do you experience shortness of breath?
Yes No Do you have asthma, bronchitis, or any other breathing problems?
Yes No Do (did) you smoke? Packs/day _____ Number of years _____ Date you quit _____
Yes No Do you consume alcohol? Drinks/week _____
Yes No Do you take or have you taken recreational drugs?
Yes No Have you taken cortisone (steroids) in the last six months?
Yes No Do you have diabetes? If so, how many months?
Yes No Have you had hepatitis, liver disease, or jaundice?
Yes No Do you have a thyroid condition? Hyperthyroid or Hypothyroid?
Yes No Do you have or have you had kidney disease?
Yes No Do you have ulcers or other stomach disorders?
Yes No Do you have a hiatal hernia?
Yes No Do you have back or neck pain?
Yes No Do you have numbness, weakness, or paralysis of your extremities?
Yes No Do you have any muscle, nerve disease, or hereditary muscle skeletal disorder?
Yes No Have you had any seizures? If so, the approximate date of the last one was _____
Yes No Do you or any of your family have sickle cell trait?
Yes No Have you or any blood relatives had difficulties with anesthesia?
Yes No Do you have bleeding problems, hemophilic disorder, or other blood factor deficiency?
Yes No Are you taking blood thinners?
Yes No Do you have loose or chipped teeth, false teeth, or bridgework?
Yes No Do you have any oral piercings (such as studs or rings) in your tongue or lip? (Please remove prior to surgery.)
Yes No Do you wear contact lenses? (Please remove prior to surgery.)
Yes No Have you ever received a blood transfusion?
Yes No Have you had any recent laboratory tests or X-rays? When? _____ Where? _____

Patient Sticker