Texas Surgical Center
midland memorial hospital

TEXAS SURGICAL CENTER

ANESTHESIA QUESTIONNAIRE

The answers to the following questions will aid in the planning of your anesthetic. Your anesthesia will be administered by:

_____ Anesthesiologist (physician)

_____ Certified Registered Nurse Anesthetist (under the direction of your surgeon)

Have you ever had surgery involving an anesthetic?

If yes, circle type:
Local General Spinal Epidural

Have you ever had a reaction/problem associated with any anesthesia? □ YES □ NO

What kind of problem?
High temperature?
Low blood pressure?
Other: _____

YES	NO	Anesthesia History/Other:
		Malignant Hyperthermia
		Previous Complication
		Postoperative Nausea or Vomiting
		Difficult Intubation
Other:		

Has a family member every had a problem with an anesthetic? □ YES □ NO
Please specify: _____

Do you have any of the following medical problems?

YES	NO	Respiratory:
		Sleep Apnea/CPAP at home
		Recent Respiratory Infection
		Asthma
		Smokeless Tobacco
		COPD/Emphysema
		Home Oxygen
		Prolonged Intubation History
		Snoring
Other:		

Do you smoke? □ YES □ NO

How many packs per day? _____
How long have you smoked? _____

Have you ever had a sleep study done? □ YES □ NO

When & what were the results? _____
_____
_____

YES	NO	Cardiovascular:
		Hypertension/ High Blood Pressure
		Angina/ Coronary Disease
		Heart Attack History
		Congestive Heart Failure History
		Stent/Angioplasty/Bypass Surgery
		Irregular Rhythm/Palpitations
		Heart Murmur/ Previous Echo
		Pacemaker/ Defibrillator
		Peripheral Vascular Disease
Other:		

YES	NO	GI/Hepatic/Renal:
		Frequent Reflux/ Ulcer
		Alcohol Use:
		Hepatitis/Liver Disease/Jaundice
		Nephrolithiasis
		Any Kidney Problems
		Dialysis-last done:_____
Other:		

YES	NO	Endocrine/Blood:
		Thyroid Disease
		Autoimmune Disease
		Steroids in previous six months
		Previous Blood Transfusion/HIV
		Bleeding Disorder/Anticoagulants
		Chemotherapy/Radiation History
		Rheumatoid Arthritis/ Lupus
Other:		

Are you a diabetic?
If yes, do you take medicine for your diabetes?
What medicine? _____
How often? _____

YES	NO	Neurologic:
		Seizure History
		Stroke/ TIA
		Chronic Back Pain/ Back Surgery
		Guillain-Barre/Polio/Spinal Cord
		Muscle Weakness/ Neuropathy
		Blackout/ Fainting
Other:		

NAME:
ACT# SEX:
DOB: AGE:

DOS:

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	Y	N		Y	N
Have you had any previous surgery? If yes, please list: _____ _____ _____ _____ _____			**Have you fallen at any time in the last 12 months?** **If yes, please explain:** _____ _____ _____ _____		
Do you or your family have any birth defects or congenital diseases? If yes, please list: _____ _____			**Are you afraid you might fall easily? Do you often feel dizzy or light-headed when standing?** **If yes, please explain:** _____ _____ _____		
Any hospitalizations in the last 6 – 12 months? If yes, please list: _____ _____ _____			**If female, are you pregnant?** **Could you be pregnant?** Date of last menstrual period: _____		
Have you had any other major illnesses? If yes, please list: _____ _____			**Have you taken any ASPIRIN in the last 24 hours?** Last time you took ASPIRIN? _____AM / PM		
Do you have a history of MDRO (multi-drug resistant organisms) or infections? (ex. MRSA, VRE) If yes, please explain: _____ _____ _____			**Do you take CORTISONE or STEROIDS?** **Are you allergic to adhesive tape?** **Are you allergic to rubber or rubber products?** **Are you allergic to any medicines?** If yes, please list on the medication list page **Are you currently taking any medications?** If yes, please list on the medication list page		
Would you rate your daily level of activity as: Light Moderate Heavy Please explain the above activities:_____ _____ _____			**Do you have dentures?** Bridgework? Capped teeth? Loose teeth? **What is your weight?** _____ **What is your height?** _____ **What is your age?** _____		
If under age 18, are your immunizations up to date?					

_____
Signature of patient/guardian

_____
Signature of Anesthesia Provider

_____ _____
Date Time

_____ _____
Date Time

NAME:
ACT#
DOB:
SEX:
AGE:

DOS: