WEBSTER OUTPATIENT SURGERY CENTER
PRE-OPERATIVE ASSESSMENT QUESTIONNAIRE

Please fill out as completely as you can

Patient Name: **Age:** **Sex:** Female **Height:** _____ **Weight:**_____

Previous Operations	Type of Anesthesia: When	General	Nerve Block	Spinal/ Epidural	Local w/ Sedation	Complications?
		☐	☐	☐	☐	
		☐	☐	☐	☐	
		☐	☐	☐	☐	
		☐	☐	☐	☐	

Family History of Anesthetic Complications? ☐ No ☐ Yes (describe)_____

MARK IF YOU HAVE HAD OR NOW HAVE ANY OF THE FOLLOWING – LEAVE BLANK IF NOT APPLICABLE

Heart/Vascular Problems	**Nerve Disease**	**Bleeding Problems**	**Dental/Vision/Hearing**
☐ Cornary artery disease	☐ Stroke/TIAs	Easy bruising	☐ Dentures/partial plate
☐ Heart attack	☐ Numbness/weakness	☐ Nosebleeds	☐ Capped teeth
☐ Chest pain	☐ Chronic pain	☐ Clotting disorder	☐ Chipped/cracked teeth
☐ Heart murmur	☐ Seizures	☐ Anticoagulant use	☐ Loose teeth
☐ Heart failure	☐ Headaches	☐ Anemia	☐ Gum disease
☐ Abnormal ECG	☐ Psychiatric illness	**Thyroid/Liver /Kidney/GI**	☐ Glasses
☐ Irregular heart beat		☐ Hypothyroid	☐ Contact lenses
☐ Pacemaker/defibrillator	**Respiratory/Lung Problems**	☐ Hyperthyroid	☐ Hearing aid
☐ Peripheral vascular disease	☐ Asthma	☐ Hepatitis/liver disease	
☐ Blood clots	☐ Bronchitis/pneumonia	☐ Diabetes	
☐ High blood pressure	☐ COPD	☐ Kidney disease	**Other**
☐ High cholesterol	☐ Pulmonary embolism	☐ Dialysis	☐ Motion sickness
	☐ Tuberculosis	☐ Ulcers	☐ Fainting
Bone/Joint Problems	☐ Abnormal chest X-ray	☐ Irritable bowel disease	☐ AIDS/HIV/MRSA/VRE
☐ Arthritis	☐ Heavy snoring	☐ Hiatal hernia	☐ Cancer
☐ Back problems	☐ Sleep apnea/CPAP use	☐ Acid reflux	☐ Drug/substance abuse
☐ Steroid/cortisone use	☐ Recent cold/flu		

List any other medical problems:

_____

Do you drink alcohol? ☐No ☐Occasionally ☐Daily – Amount per day: _____

Are you a Tobacco smoker? ☐No ☐Yes How many packs per day _____ How many years _____ Year Quit_____

Are you a Cannabis smoker? ☐No ☐Yes How many packs per day _____ How many years _____ Year Quit_____

Are you pregnant? ☐No ☐Yes Might you be pregnant? No Date of last menstrual period _____

Signature: _____ **Date/Time:** _____ **Signature:** _____ **Date:** _____ **Time:** _____

☐ RN ☐ Patient **filling out questionnaire** ☐ Anesthesiologist MD ☐ RN **reviewing questionnaire**

, PT ID