Coral Desert SURGERY CENTER

ANESTHESIA QUESTIONNAIRE

1490 E. Foremaster Dr. Bldg. C, St. George Ut. 84790 (435) 674-5230 Fax (435) 674-5231

Patient Name:			
Age:	Height: Ft. In.	Weight:	Primary Care Physician:

Y	N	SPECIAL CONSIDERATIONS	
		COMMUNICATION PROBLEMS HEARING / VISION	I HAVE DISCUSSED WITH MY SURGEON; THE NECESSITY AND APPROPRIATENESS OF THE PROPOSED SURGERY AS WELL AS ALTERNATIVE TREATMENTS. □ YES □ NO COMMENTS:_____
		PHYSICAL LIMITATIONS?	
		LATEX ALLERGIES: □ NONE	
		MEDICATION ALLERGIES: □ NONE	
		FOOD / OTHERS ALLERGIES: □ NONE	

LIST ALL CURRENT AND RECENT MEDICATIONS or ATTACH SEPARATE SHEET
(INCLUDE PRESCRIPTIONS, EYE DROPS, & OVER-THE-COUNTER MEDS / VITAMINS AND THE DOSAGE)

_____ _____ _____
_____ _____ _____
_____ _____ _____

LIST PREVIOUS HOSPITALIZATION OR OPERATIONS (INDICATE APPROXIMATE YEAR)

_____ _____ _____
_____ _____ _____

** HAVE YOU HAD A BAD REACTION TO ANESTHESIA □YES □N **HAS A BLOOD RELATIVE HAD A BAD REACTION TO ANESTHESIA □YES □

DO YOU HAVE or HAVE YOU HAD	Y	N		Y	N
DIABETES (Controlled by: Diet, Pills, or Insulin)			ANY ILLNESS, COLD, COUGH, OR FEVER IN THE LAST WEEK?		
HYPOGLYCEMIA (Low Blood Sugar)			ANY RECENT EXPOSURE TO COMMUNICABLE DISEASES?		
HEART PROBLEMS (Rheumatic Fever, Murmur, Chest Pain, Heart Attack, Irregular heart Beat, EKG Changes, Angina, Ankle Swelling, Valve Replacement)			(FEMALES) IS THERE A POSSIBILITY YOU ARE PREGNANT? LAST MENSTRUAL PERIOD: _____		
THYROID PROBLEMS			DO YOU HAVE A HISTORY OF SMOKING? PACKS PER DAY? _____ DATE QUIT? _____		
BLOOD CLOTS, TRANSFUSION PROBLEMS			DO YOU DRINK ALCOHOLIC BEVERAGES? HOW OFTEN? _____ HOW MUCH? _____		
BLEEDING TENDENCY (Hemophilia)			DO YOU HAVE A HISTORY OF OR ARE YOU TAKING ANY RECREATIONAL DRUGS?		
HIGH BLOOD PRESSURE			DO YOU HAVE ANY OF THE FOLLOWING □BRACES □FALSE TEETH □BRIDGES □RETAINERS □LOOSE TEETH □CAPPED TEETH □CHIPPED TEETH		
STROKE (Weakness or Numbness on one side, Difficulty Speaking, Loss of Vision)					
SEIZURES (Epilepsy, Convulsions, Blackouts)			DO YOU WEAR CONTACT LENSES?		
SEVERE HEADACHES			ARE THERE ANY PAIN MEDICATIONS YOU CAN NOT TAKE?		
LUNG PROBLEMS (Asthma, Chronic Cough, Pneumonia, Wheezing, Shortness of Breath, Emphysema, Abnormal chest X-ray)			DO YOU HAVE AN ADVANCED DIRECTIVE OR LIVING WILL? (If yes please bring a copy with you)		
TUBERCULOSIS / TB			WOULD YOU LIKE TO DISCUSS ANY CONCERNS OR FEARS YOU MIGHT HAVE REGARDING THIS PROCEDURE?		
SLEEP APNEA (Breathing Interruption During Sleep or on Oxygen)			HAVE YOU MADE ARRANGEMENTS FOR ASSISTANCE AFTER YOUR SURGERY?		
LIVER PROBLEMS (Jaundice, Hepatitis)			DO YOU NEED A RELEASE FOR WORK OR SCHOOL?		
KIDNEY, BLADDER, OR PROSTATE PROBLEMS (Infections)			**IF THE PATIENT IS A CHILD**		
STOMACH PROBLEMS (Ulcer, Hiatal Hernia, Reflux, Heartburn)			WAS THE CHILD PREMATURE?		
BOWEL PROBLEMS (Irritable Bowl, Diverticulosis)			ANY BIRTH DEFECTS OR DEVELOPMENTAL PROBLEMS?		
BACK, NECK, OR BROKEN BONES IN SPINE (Strain, Disc Problems, Numbness, or Tingling of Hands)			ANY IMMUNIZATION PROBLEMS OR DELAYS?		
ARE YOU RECEIVING TREATMENT FOR GLAUCOMA			ANY HISTORY OF HOLDING BREATH, CROUP, OR BREATHING PROBLEMS		
IMMUNOCOMPROMISED (HIV, ORGAN TRANSPLANT)			COMMENTS:		
DIFFICULTY OPENING MOUTH (TMJ)					
ARTHRITIS / RESTRICTIONS IN MOVEMENT					
MUSCLE DISORDERS (MD, Myasthenia Gravis)					
CANCER					
MENTAL HEALTH ISSUES / PHOBIAS					
SKIN DISORDERS (Eczema)					
OTHER MEDICAL PROBLEMS / PARKINSONS DISEASE					

PATIENT / SO SIGNATURE X _____

PATIENT STICKER