

**Complete both sides and leave with Surgeon's Office or fax to 982-8239**

**www.mjh.anesthesiology.com**

**Ambulatory Day Surgery  
Fax (434) 982-8239.**

Date of Surgery	Surgeon	Type of Surgery		
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Patient Name	Height	Age	Weight
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Yes No  
  Previous surgery/anesthesia? List what & when \_\_\_\_\_  
  Have you, or a blood relative, had any problems with anesthesia, including: nausea, weakness, difficulty breathing or high fever? If yes, explain \_\_\_\_\_

**For Children under Age 18:**

Yes No	Yes No
<input type="checkbox"/> <input type="checkbox"/> Premature birth	<input type="checkbox"/> <input type="checkbox"/> Heart problems after birth
<input type="checkbox"/> <input type="checkbox"/> Breathing problems after birth	<input type="checkbox"/> <input type="checkbox"/> Respiratory illness in past month
<input type="checkbox"/> <input type="checkbox"/> Other conditions being treated for: _____	<input type="checkbox"/> <input type="checkbox"/> Family history of muscle disease

**For Ages 18 and Older:**

Yes No	Yes No
<input type="checkbox"/> <input type="checkbox"/> Heart attack-when _____	<input type="checkbox"/> <input type="checkbox"/> Chronic Pain
<input type="checkbox"/> <input type="checkbox"/> Heart surgery-what & when _____	<input type="checkbox"/> <input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> <input type="checkbox"/> Pacemaker/internal defibrillator	<input type="checkbox"/> <input type="checkbox"/> Stroke-when _____
<input type="checkbox"/> <input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> <input type="checkbox"/> Seizures-type _____
<input type="checkbox"/> <input type="checkbox"/> Angina/chest pain	<input type="checkbox"/> <input type="checkbox"/> Frequent heartburn, hiatal hernia, reflux
<input type="checkbox"/> <input type="checkbox"/> Heart murmur requiring treatment	<input type="checkbox"/> <input type="checkbox"/> Diabetes/glucose intolerance avg. morning blood sugar _____
<input type="checkbox"/> <input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> <input type="checkbox"/> Bleeding problems/blood clots
<input type="checkbox"/> <input type="checkbox"/> Last EKG: when & where? _____	<input type="checkbox"/> <input type="checkbox"/> Sickle cell disease or trait
<input type="checkbox"/> <input type="checkbox"/> High blood pressure	<input type="checkbox"/> <input type="checkbox"/> Hepatitis or jaundice
<input type="checkbox"/> <input type="checkbox"/> Elevated Cholesterol	<input type="checkbox"/> <input type="checkbox"/> Cancer-of what & when _____
<input type="checkbox"/> <input type="checkbox"/> Fainting spells	<input type="checkbox"/> <input type="checkbox"/> Kidney disease/dialysis
<input type="checkbox"/> <input type="checkbox"/> Shortness of breath	<input type="checkbox"/> <input type="checkbox"/> Mediport, portacath, vein shunt
<input type="checkbox"/> <input type="checkbox"/> Asthma/wheezing	<input type="checkbox"/> <input type="checkbox"/> Prosthesis/implants _____
<input type="checkbox"/> <input type="checkbox"/> Emphysema/chronic bronchitis or/lung disease	<input type="checkbox"/> <input type="checkbox"/> Body piercings/jewelry
<input type="checkbox"/> <input type="checkbox"/> Snore/been told you stop breathing while you sleep	<input type="checkbox"/> <input type="checkbox"/> Have a communicable disease (i.e. TB, HIV, VD, hepatitis, etc.)
<input type="checkbox"/> <input type="checkbox"/> Frequent morning headaches or fall asleep easily during the day	<input type="checkbox"/> <input type="checkbox"/> Are you pregnant?
<input type="checkbox"/> <input type="checkbox"/> Sleep apnea	<input type="checkbox"/> <input type="checkbox"/> Smoke: packs per day _____
<input type="checkbox"/> <input type="checkbox"/> Use or been prescribed CPAP/BiPAP machine	<input type="checkbox"/> <input type="checkbox"/> Ever smoked in the past? Quit when? _____
<input type="checkbox"/> <input type="checkbox"/> Back/neck surgery or problems	<input type="checkbox"/> <input type="checkbox"/> Drink alcohol regularly/how much? _____
<input type="checkbox"/> <input type="checkbox"/> Arthritis requiring treatment	<input type="checkbox"/> <input type="checkbox"/> Object to blood transfusions
<input type="checkbox"/> <input type="checkbox"/> Problems opening mouth (TMJ)	<input type="checkbox"/> <input type="checkbox"/> Dentures/partials/loose or chipped teeth
<input type="checkbox"/> <input type="checkbox"/> Numbness/weakness of muscles where _____	<input type="checkbox"/> <input type="checkbox"/> Other conditions being treated for _____

What is the most activity you can do before you get tired or short of breath and have to stop?

- Walk across room    Walk one block    Walk one mile    Run a mile

If one block or less, what limits your activity? \_\_\_\_\_

Any other information you feel the anesthesiologist should know? \_\_\_\_\_ **OVER ►**

*Martha*  
**Jefferson Hospital**

**ANESTHESIA PREOPERATIVE  
QUESTIONNAIRE**

