Allen County Hospital
Pre-Anesthesia Questionnaire

Name:_____Age:_____Birthdate:_____
Party to accompany you to and from hospital:_____
Relationship to patient:_____

Personal History: Please check YES or NO. Answer questions where applicable.

Yes	No	
☐	☐	Have you recently had a cold or flu?
☐	☐	Are you allergic to latex (rubber) products?
☐	☐	Have you experienced chest pain?
☐	☐	Do you have hypertension (high blood pressure)?
☐	☐	Do you experience shortness of breath?
☐	☐	Do you have asthma, bronchitis, or any other breathing problem?
☐	☐	Do you (or did you) smoke? Packs/day_____ Number of years_____ Date you quit_____
☐	☐	Do you consume alcohol? Drinks/week_____
☐	☐	Do you take or have you taken recreational drugs?
☐	☐	Have you taken cortisone (steroids) in the last six months?
☐	☐	Do you have diabetes?
☐	☐	Have you had hepatitis, liver disease, or jaundice?
☐	☐	Do you have a thyroid condition?
☐	☐	Do you have or have you had kidney disease?
☐	☐	Do you have ulcers or other stomach disorders?
☐	☐	Do you have a hiatal hernia?
☐	☐	Do you have back or neck pain?
☐	☐	Do you have numbness, weakness, or paralysis of your extremities?
☐	☐	Do you have any muscle or nerve disease?
☐	☐	Do you or any of your family have sickle cell trait?
☐	☐	Have you or any blood relatives had difficulties with anesthesia?
☐	☐	Do you have bleeding problems?
☐	☐	Do you have loose chipped, false teeth, or bridgework?
☐	☐	Do you wear contact lenses, glasses, or hearing aide?
☐	☐	Have you received a blood transfusion?
☐	☐	(Women) Are you pregnant? Due Date_____
☐	☐	Do you wear any prosthetic device?
☐	☐	Do you have a seizure disorder?
☐	☐	Are you using aspirin or aspirin like products?_____

List any allergies you have:

_____
_____
_____
_____
_____
_____

List all previous surgeries and dates:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

List of all medications (and doses) you are taking. **(Prescription and over the counter)**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____
Signature of person completing form Time/Date

_____ _____
Nurse Signature Time/Date