roxbury
SURGERY CENTER

PRE-ANESTHESIA/SURGERY QUESTIONNAIRE

1. Name of your regular family doctor ______________________ Phone ____________
   OR ❑ I do not have a regular family doctor
2. Have you ever had any problems with blood pressure, previous heart disease, palpitations or angina? ❑ Yes ❑ No
   If yes, please explain: ______________________
3. Have you had an EKG in the past? ❑ Yes ❑ No If yes, where? when ______________________
4. Have you had any (Circle) breathing problems, asthma, hay fever, chronic bronchitis, emphysema or shortness of breath?
5. Have you had any (Circle) seizures, convulsions, migraine headaches, fainting spells or stroke?
6. Have you had (Circle) jaundice, hepatitis, liver disease or blood transfusion reactions?
7. Do you have (Circle) diabetes, hypoglycemia or thyroid problems?
8. Do you have kidney problems? ❑ Yes ❑ No
9. Have you had (Circle) a cold, sore throat, or flu in the last two weeks?
10. Any recent exposure to tuberculosis? ❑ Yes ❑ No Any of the following symptoms: night sweats, cough with bloody sputum?
11. Within the last two weeks have you had any exposure to chicken pox, mumps, measles (rubeola), German measles (rubella)?
    ❑ Yes ❑ No
12. Do you have any (Circle) physical disabilities, back pain, arthritis or bursitis?
13. Do you have sleep apnea? C-PAP? Sleeping disorders? Snoring? ❑ Yes ❑ No
14. Any other medical conditions? List: ______________________
15. Do you have any implants? ❑ Yes ❑ No (Cardiac, Cosmetic, Orthopedic) List: ______________________
16. Have you ever had motion sickness?❑ Yes ❑ No
17. Do you smoke? ❑ Yes ❑ No How much/day? ______________________
18. Do you drink alcoholic beverages? ❑ Yes ❑ No How much/week? ______________________
19. Do you use recreational drugs? ❑ Yes ❑ No Please list ______________________
20. Do you have (Circle) any loose teeth, dentures, permanent or removable bridges or front capped teeth?
21. Do you wear contacts? ❑ Yes ❑ No
22. Do you have any difficulty opening your mouth? ❑ Yes ❑ No
23. Have you or any blood relative had an unusual reaction to anesthesia or malignant hyperthermia? ❑ Yes ❑ No
24. Are you allergic to anything? ❑ Yes ❑ No List: ______________________
25. Do you have a latex allergy? ❑ Yes ❑ No
26. Do you currently take any medications ? ❑ Yes ❑ No
27. Within the last year have you had cortisone or steroids? ❑ Yes ❑ No
28. Within the last two weeks have you taken (Circle) a tranquilizer, diet pills or herbal medications? ❑ Yes ❑ No
29. Have you taken any medication today? ❑ Yes ❑ No List: ______________________
30. Do you use aspirin, ibuprophen (Motrin), Advil, Aleve, Naproxen or Anaprox? ❑ Yes ❑ No
    Others ______________________ Last date taken? ______________________
31. Do you use blood thinners (Heparin, Lovenox, Coumadin, etc.)? ❑ Yes ❑ No Last date taken? ____________
32. Do you have bleeding tendencies? ❑ Yes ❑ No
33. Could you be pregnant at this time? ❑ Yes ❑ No Date of last menstrual period: ______________________
34. Circle pain medications you have ever taken: | Tylenol | Percocet | Codeine | Aspirin | Darvocet | Vicodin | Other
35. Height: ____________ Weight: ____________

Previous Operations	Year Done	Type of Anesthesia (General, Epidural, Spinal, Local)	Complications (i.e. fever, nausea, vomiting, low blood pressure)

COMPLETED BY: ______________________

RELATIONSHIP: ______________________ DATE: ______________________

REVIEWED BY: PRE-OP RN: ______________________OR R.N.: ______________________