PRE-OPERATIVE ASSESSMENT QUESTIONNAIRE

Patient Name: _____ DOB:_____ Age:_____ Sex: M / F

Drug Allergy ☐ No ☐ Yes (list, include reaction)

_____

Latex Allergy ☐ No ☐ Yes

Previous Operations When & Where	**Complications?**

Family History of Anesthetic Complications? ☐ No ☐ Yes
(describe)_____ **Height: _____Weight:_____BMI:_____**

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**
☐ Heart Attack	☐ Stroke	☐ Easy Bruising	☐ Dentures / Partial Plate
☐ Heart Failure	☐ Transient Ischemic Attack	☐ Nosebleeds	☐ Capped Teeth
☐ Heart Murmurs	☐ Numbness / Weakness	☐ Blood Transfusion	☐ Chipped Teeth/Cracked Teeth
☐ Chest Pain	☐ Seizures	☐ Anemia	☐ Loose Teeth
☐ Abnormal ECG	☐ Headaches	**Thyroid / Liver / Kidney / GI**	☐ Gum Disease
☐ Irregular Heart Beat	☐ Psychiatric Illness	☐ Hypothyroid	☐ Contact Lenses
☐ Pacemaker	**Respiratory / Lung Problems**	☐ Hyperthyroid	☐ Glasses
☐ Cardiac Defibrillator	☐ Asthma	☐ Hepatitis	☐ Glaucoma
☐ Peripheral Vascular Disease	☐ Bronchitis	☐ Diabetes	☐ Hearing Aid
☐ Blood Clots	☐ COPD	☐ Kidney Disease	**Other**
☐ High Blood Pressure	☐ Pneumonia	☐ Dialysis	☐ Motion Sickness
☐	☐ Tuberculosis	☐ Ulcers	☐ Fainting
Bone / Joint Problems	☐ Abnormal Chest X-ray	☐ Irritable Bowel Disease	☐ Drug / Substance Abuse
☐ Arthritis	☐ Heavy Snoring	☐ Hiatal Hernia	☐ Recent Infectious Exposure
☐ Back Problems	☐ Sleep Apnea	☐ Acid Reflux	☐ AIDS /HIV/MRSA/VRE
☐ Steroid / Cortisone Use	☐ Recent Cold / Flu	☐	☐ Cancer

List any other medical problems:

_____

Do you drink alcohol? ☐ No ☐ Occasionally ☐ Daily – Amount per day: _____
Have you ever smoked? ☐ No ☐ Yes How many packs per day _____How many years _____Year quit _____
Are you pregnant? ☐ No ☐ Yes Date of last menstrual period _____

Signature: _____ **Date:** _____ **Signature:** _____ **Date:** _____
filling out questionnaire ☐ RN ☐ Patient **reviewing questionnaire** ☐ RN ☐ Patient

Patient Label