THE CENTER FOR OUTPATIENT MEDICINE, LLC
PATIENT PRE-ANESTHESIA/SURGERY QUESTIONNAIRE

Name:_____ Home Phone:_____ Work Phone_____
Surgeon:_____ Medical Doctor: _____ Surgery date:_____
Height:_____ *Weight:_____ Age:_____ Birthdate: _____
*Be sure weight is accurate because it will be used to calculate medication dosages, etc.

List any **allergies and reactions to food, medication, latex, or rubber**.

_____

_____

☐ NONE

List any previous **surgeries**, type and year:

_____

_____

_____

_____

_____

☐ NONE

Surgical /Anesthetic **Complications:**
Nausea ☐ YES ☐ NO
Vomiting ☐ YES ☐ NO
Bleeding ☐ YES ☐ NO

**Family history of anesthetic problems?**
☐ YES_____
☐ NO

**DO YOU HAVE, OR HAVE YOU EVER HAD:**

| PROBLEM | YES | NO | PROBLEM | YES | NO |
|---|---|---|---|---|---|
| Frequent Shortness of Breath?---------- (Circle one) Mild / Moderate / Severe | ☐ | ☐ | Leaky Heart Valve, Heart Murmur---------- | ☐ | ☐ |
| | | | Stroke, CVA, TIA---------- | ☐ | ☐ |
| Asthma---------- | ☐ | ☐ | Seizure Disorder---------- | ☐ | ☐ |
| Emphysema---------- | ☐ | ☐ | Parkinson's Disease---------- | ☐ | ☐ |
| Bronchitis---------- | ☐ | ☐ | Multiple Sclerosis---------- | ☐ | ☐ |
| Chronic Cough---------- | ☐ | ☐ | Myasthenia Gravis---------- | ☐ | ☐ |
| Sleep Apnea---------- | ☐ | ☐ | Liver Disease (Hepatitis, Cirrhosis)------- | ☐ | ☐ |
| CPAP?---------- | ☐ | ☐ | Rheumatoid Arthritis---------- | ☐ | ☐ |
| Heavy Snoring---------- | ☐ | ☐ | Mental Health Problems/Depression-------- | ☐ | ☐ |
| Recent Respiratory Infection---------- | ☐ | ☐ | Thyroid Problems---------- | ☐ | ☐ |
| Bleeding Problems---------- | ☐ | ☐ | Neck Pain/ Problems---------- | ☐ | ☐ |
| Diabetes---------- | ☐ | ☐ | Kidney Disease---------- | ☐ | ☐ |
| High Blood Pressure---------- | ☐ | ☐ | Cancer (Type_____) | ☐ | ☐ |
| Heart Attack---------- | ☐ | ☐ | TMJ or Jaw Problems---------- | ☐ | ☐ |
| Coronary Artery Disease---------- | ☐ | ☐ | Acid Reflux/Frequent Heartburn---------- | ☐ | ☐ |
| Angina---------- | ☐ | ☐ | Ulcer---------- | ☐ | ☐ |
| Fast or Irregular Heart Beats---------- | ☐ | ☐ | Hiatal Hernia---------- | ☐ | ☐ |
| Congestive Heart Failure---------- | ☐ | ☐ | Blood Disease, Anemia---------- | ☐ | ☐ |
| Pacemaker (Date Placed _____)-- | ☐ | ☐ | Motion Sickness---------- | ☐ | ☐ |
| Mitral Valve Prolapse---------- | ☐ | ☐ | Any other medical condition?---------- | ☐ | ☐ |

Explain "Yes" Answers: _____

_____

| YES | NO | Question |
|---|---|---|
| ☐ | ☐ | Any history of smoking? How much daily?_____ How many years?_____ Quit?_____ When?_____ |
| ☐ | ☐ | Do you drink alcohol? How much?_____ |
| ☐ | ☐ | Do you use any recreational drugs? _____ |
| ☐ | ☐ | Do you wear dentures? (Circle) LOWER UPPER PARTIAL |
| ☐ | ☐ | Do you have capped front teeth? |
| ☐ | ☐ | Have you been hospitalized in the last 3 months? Reason_____ |
| ☐ | ☐ | Have you been treated for an antibiotic resistant infection? |
| ☐ | ☐ | Have you ever been diagnosed with tuberculosis? If yes, when _____? Are you currently being treated? ☐ YES ☐ NO |
| ☐ | ☐ | Have you ever been diagnosed with an infectious disease? If yes, when_____? |
| ☐ | ☐ | Have you recently been exposed to an infectious disease? If yes, when _____? |

**FEMALE PATIENTS**: Last Period:_____
☐ Post menopausal greater than 2 years
☐ Hysterectomy ☐ Tubal Ligation ☐ Lactating

**MALE PATIENTS:**
Do you wear a beard? ☐ YES ☐ NO

**ALL PATIENTS: You will meet the anesthesiologist the day of surgery.**
Do you want to set up an appointment to meet an anesthesiologist ***prior to the day of surgery***? ☐ YES ☐ NO

| Do you have questions about any of the following: | | Do you have any of the following which may impact your learning or care? | | Comments/Explanations |
|---|---|---|---|---|
| | None | | None | |
| | Medication | | Cognitive Impairment | |
| | Procedure/Surgery | | Hearing Limitations | |
| | Pain Management | | Visual Limitations | |
| | Wound Care | | Physical Limitations | |
| | | | Speech/Language | |
| | | | Cultural/Religious Beliefs | |

Do you have an advanced directive? ☐ Yes ☐ No (If "yes" please provide a copy upon registration or admission.)

Who filled out this form? ☐ SELF ☐ Other _____

Patient or Responsible Adult Signature: _____ Date:_____

May we leave a message at your home, if needed, to discuss your procedure? ☐ Yes ☐ No
With whom, other than yourself, may we discuss information about your procedure? ☐ Discuss only with me.
☐ _____

## FOR TCOM USE ONLY

Surgery #1 Reviewed by: RN _____Date_____
Surgery #2 Reviewed by: RN _____Date_____

PRETESTING: Date:_____ Time:_____ Pulse_____ Resp_____ BP_____ SpO2 on RA_____

BMI_____ _____

_____RN

Pre-tests done today: ☐ BMP/CMP ☐ CBC ☐ EKG ☐ CXR ☐ Anesthesia Appointment ☐ Other:

TYPE OF ANESTHESIA REQUESTED: Surgery #1 _____ Surgery #2_____
ANESTHESIA NOTES: _____
_____
_____
_____

Mental status: Alert & Oriented X 3 ☐
CV: RR/ no murmur, gallop ☐
Lungs: CTA ☐
A/W: mallampati I II III IV

| | | | | |
|---|---|---|---|---|
| TEETH | OK | ☐ | ANTERIOR CAPS | ☐ |
| TMJ MOBILITY | WNL | ☐ | DECREASED | ☐ |
| NECK EXTENSION | WNL | ☐ | DECREASED | ☐ |
| BEARD | | ☐ | TMD DECREASED | ☐ |
| PREDICTED DIFFICULT AIRWAY | | ☐ | | |

_____

**DIAGNOSTIC STUDIES**

EKG:

Chemistries:

Other:

SURGERY #1_____
_____
_____

☐ Confirmation of: identity, procedure, procedure site, and consent
ASA physical status: 1 2 3 4 E
Anesthetic plan:
☐ GA ☐ MAC ☐ IVB ☐ Peripheral block
☐ SAB ☐ Peripheral block for pain control
☐ Physical Exam Unchanged from Surgery #1

_____ MD/DO
☐ Form reviewed along with Patient identity, procedure, procedure site, and consent per MD/DO/CRNA if applicable

_____ MD/DO/CRNA

SURGERY #2_____
_____
_____

☐ Confirmation of: identity, procedure, procedure site, and consent
ASA physical status: 1 2 3 4 E
Anesthetic plan:
☐ GA ☐ MAC ☐ IVB ☐ Peripheral block
☐ SAB ☐ Peripheral block for pain control
☐ Physical Exam Unchanged from Surgery #1

_____ MD/DO
☐ Form reviewed along with Patient identity, procedure, procedure site, and consent per MD/DO/CRNA if applicable

_____ MD/DO/CRNA