Surgeons Surgery Center

Pre-Anesthesia Record (Adult 18 years and over)

Instructions to Patient: Please print or indicate by a check mark (√) your answer to each question. These answers will greatly help your anesthesiologist to give you the best possible care during your procedure. If you do not understand any question (or your answer is uncertain) simply place a question mark(?) next to the answer column.

Name:_____ Date of Birth:_____ Age:_____
Sex: M_____F Height:_____ Weight:_____lbs. Right Handed_____ or Left Handed_____

1. Are you taking or have you taken Blood thinners?
☐No ☐YES, if so last does was:_____
2. List all allergies to medications/Include food(s).
_____ _____
_____ _____
_____ _____

3. List all previous surgeries (and when).
_____

_____

_____

	Yes	No
4. Have you or your family had a high or unexplained fever (hyperthermia) during or after surgery?……..	☐	☐
5. Have you or any family member had an unusual reaction to anesthesia?…….	☐	☐
6. Do you: Drink Alcoholic Beverages?……	☐	☐
If yes, how much per day?_____		
Use Addicting Drugs?_____		
Smoke? If yes,_____ cigarettes per day……	☐	☐
7. Have you had recent weight changes?……..	☐	☐
8. Are you pregnant?…….	☐	☐
9. Do you have any false teeth, loose teeth, caps or bridgework?	☐	☐
10. Have you been diagnosed or have problems with Sleep Apnea or severe snoring?…….	☐	☐
11. Do you have a Latex sensitivity?……..	☐	☐

Have you or Have you Had	Yes	No
12. Glaucoma	☐	☐
13. Stiff Jaw or Neck	☐	☐
14. A cold in the past month	☐	☐
15. Shortness of breath	☐	☐
16. Chronic cough	☐	☐
17. Asthma	☐	☐
18. Heart Attack	☐	☐
19. Chest pain;Angina	☐	☐
20. Palpitations	☐	☐
21. High Blood Pressure	☐	☐
22. Hepatitis	☐	☐
23. Hiatal Hernia	☐	☐
24. Rheumatic Fever	☐	☐
25. Ulcers	☐	☐
26. Stoke	☐	☐
27. Seizures	☐	☐
28. Blackouts	☐	☐
29. Back Problems	☐	☐
30. Muscle Diseases	☐	☐
31. Arthritis	☐	☐
32. Diabetes	☐	☐
33. Thyroid Problems	☐	☐
34. Bleeding Tendencies	☐	☐
35. Sickle Cell Anemia	☐	☐
36. Blood Transfusions	☐	☐
37. Kidney Disease	☐	☐
38. Aids/HIV Positive	☐	☐
39. Any other medical problems not listed		
40. Do you have any concerns about your safety and well being at home?……	☐	☐

_____

_____

_____

Is there any other information we should know that would help us with your care today?_____

_____

_____

Who is driving you home today?_____ Relationship:_____

☐ Staying at facility ☐ Will return at (time)_____ ☐ Please call contact#:_____

_____ _____

Signature (patient or person filling our form) Date & Time