PRE-ANESTHESIA QUESTIONNAIRE

Ramapo Valley Surgical Center

Name			
Physician/Surgeon			Label
Age	Height	Weight	

	YES	NO	Please List Any Allergies/Unusual Reactions to Medications
Please Mark All Boxes			
Recent Cold/Flu			
Asthma/COPD/Emphysema			
Pneumonia/TB			
Chronic Cough			
Nighttime Snoring			
Sleep Apnea/CPAP			
Smoking [ ] Yes [ ] No [ ] Every Day [ ] Some Days [ ] Former [ ] Never			
Rheumatic Fever			**Please List All Medications and/or Supplements**
Heart Murmur			
High Blood Pressure			
Low Blood Pressure			**[ ] NONE**
Chest Pain/Angina			Drug/Medication Name / Dose / Fequency
Heart Attack/MI			
Irregular Heart Beat			
Palpitations			
Shortness of Breath			
How Many Blocks can you Walk Without Shortness of Breath?			
Pacemaker/AICD (Defib)			**Please List Any Previous Surgeries**
Angioplasty or Stent			**[ ] NONE**
Bleeding Tendencies			
Jaundice/Hepatitis			
Acid Reflux/GERD			
Back or Neck Pain/Sciatica			**Malignant Hyperthermia Screening**
Arthritis			Do you have a family history of unexplained death following General Anesthesia?
Weakness/Numbness in Arms or Legs			☐ Yes ☐ No
Disabling accident or Fall			Do you have a personal or family history of malignant hyperthermia?
Epilepsy/Convulsions			☐ Yes ☐ No
Stroke/CVA			Do you have a muscle or neuromuscular disorder?
Paralysis/Polio			☐ Yes ☐ No
Thyroid Disease			Do you have high temperatures following exercise?
Diabetes			☐ Yes ☐ No
Kidney Disease			Do you have a personal history of muscle spasm, dark or chocolate colored urine, or unanticipated fever immediately following anesthesia or serious exercise?
Drink Alcoholic Beverages			☐ Yes ☐ No
Recreational Drugs			
Blood Transfusions			Internist/Family Doctor Name — *rev 3-23-17*
Denture/Caps/Loose Teeth			
Dental Bonding/Laminates			
Motion Sickness/Vertigo			Anesthesiologist Signature — Date
Could You be Pregnant			
Last Menstrual Period Date			Patient Signature — Date
Unusual Reaction to Anesthesia in Past			**Additional Comments:**