Patient Name:
DOB:

Pre-Anesthesia Patient Questionnaire
(Patient completed or Provider assisted)

SWEDISHAMERICAN
A DIVISION OF UW HEALTH

	YES	NO
Activity Level		
Are you limited in your activity because you are short of breath or tired (not because of joint or muscle aches/weakness)?		
Do you have difficulty walking slowly for 2 level blocks, doing light house or yard work (dusting, mowing lawn, washing dishes), or light recreational activities (billiards, canoeing, golfing with cart), moderate house work vacuuming, sweeping carrying groceries)		
General		
How much do you weigh? (lb)		
How tall are you? (ft/in)		
Do you have **implanted devices** such as shunts, medication pumps, or electronic spinal / brain stimulation devices?		
Females: Is there a chance that you could be **pregnant**, trying to get pregnant, or do you know that you are now pregnant?		
Pregnancy (If applicable)		
What is your expected date of delivery?		
Do you have a history of preeclampsia, eclampsia, or high blood pressure with pregnancy?		
Do you have a history of problems with an epidural or spinal during pregnancy?		
Anesthesia History or Concerns		
Have you ever had **serious** problems with anesthesia?		
Has anyone in your family had **serious** problems with anesthesia?		
Do you or anyone in your family have a condition known as **"Malignant Hyperthermia"**?		
Do you have any beliefs that prohibit you from receiving blood products?		
Do you have significant concerns about your upcoming anesthetic?		
Nervous System		
Have you ever had a **stroke**, head injury, or brain bleeding?		
Do you have a paralyzed arm or leg, or significant weakness?		
Do you have chronic pain?		
Heart		
Do you have a heart **pacemaker, defibrillator**, or other device?		
If yes, list type:		
If yes, last date checked:		
Have you ever had a **heart attack**, or other "blocked" blood vessels?		
Have you previously had, or do you now have any chest pressure or **chest pain**, especially during activity?		
Have you had, or been treated for, heart failure or fluid in your lungs in the past 3 months?		
Do you have high blood pressure?		
Have you had a valve replaced?		
Have you experienced an abnormally slow, fast, or irregular heart rate?		
Have you had stents placed in your heart, or open heart surgery?		
Breathing		
Do you snore really loud and pause your breathing in your sleep?		
Have you been diagnosed with Sleep Apnea?		

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	YES	NO
Do you use oxygen therapy at home?		
Do you have chronic bronchitis, emphysema, or asthma?		
Have you been diagnosed with pulmonary embolism (or 'blood clot in your lungs')?		
Have you had or been diagnosed with pneumonia in the past 30 days?		
Have you had a recent upper respiratory infection?		
Endocrine		
Do you have diabetes?		
Do you use steroids on a regular basis?		
GI, Kidneys and Liver		
Have you ever had Hepatitis (or 'yellow jaundice')?		
Do you have liver cirrhosis?		
Do you have 'heartburn' or gastroesophogeal reflux?		
Are you on dialysis?		
Do you have end stage renal disease?		
Bleeding or Clotting		
Do you or your family have a history of serious **bleeding** or **clotting** problems?		
Do you take **chronic blood thinners**? (ex. Warfarin, Xarelto, Heparin, Lovenox, Aspirin, Plavix)		
Infections		
Have you had "**MRSA**" (resistant staph bacteria) infection or "**C Diff**" diarrhea infection?		
Have you ever had Tuberculosis or a positive TB test or coughed up blood?		
Have you ever been tested for HIV or think you could be HIV positive?		
Pediatrics Only		
Does your child have musclar distrophies or any muscular disorders?		
Does your child have a history of congenital heart disease?		
Does your child have a history of asthma?		
Has your child had a fever or upper respiratory infection in the past 30 days?		