SOUTH LAKE SURGERY CENTER

# Anesthesia Questionnaire

Patient Name: ______________________________________________ Age: ______________

Date of Birth: ______________________________________________ Sex: M or F

Surgeon: ______________________________________________ Height: ___________

Date of Surgery: ______________________________________________ Weight: ___________

Please list all food and drug allergies:

______________________________________________________________________________

______________________________________________________________________________

Please list all medications with dosages:

| Medication Name | Dosage | Taken how many times per day |
|---|---|---|
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Please list all previous surgeries:

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______________________________________________________________________________

______________________________________________________________________________

Have you had any problems with anesthesia in the past? Yes or No

Do you smoke? Yes or No If yes, how many packs per day? _______________________

Do you drink alcohol? Yes or No If yes, how many times per week? _______________________

Review of Systems:

| | |
|---|---|
| Do you have high blood pressure? | Yes / No |
| Do you have an irregular heartbeat? | Yes / No |
| Do you have a pacemaker or defibrillator? | Yes / No |
| Do you have any heart stents? | Yes / No |
| Have you ever had a heart attack? | Yes / No |
| Have you ever had open heart bypass surgery? | Yes / No |
| Have you ever had a seizure? | Yes / No |
| Have you ever had a stroke? | Yes / No |
| Have you ever had brain surgery? | Yes / No |
| Do you have acid reflux? | Yes / No |
| Have you ever had a stomach ulcer? | Yes / No |
| Have you ever had hepatitis? | Yes / No |
| Do you have diabetes? | Yes / No |
| Have you ever had thyroid disease? | Yes / No |
| Do you have asthma? | Yes / No |
| Do you have emphysema? | Yes / No |
| Have you ever been diagnosed with sleep apnea? | Yes / No |
| Do you have chronic bronchitis? | Yes / No |
| Do you have any bleeding disorders? | Yes / No |
| Do you have any kidney problems? | Yes / No |

Please list any other health concerns you may have below:

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