Cleveland Nasal Sinus & Sleep Cer

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PREANESTHETIC QUESTIONNAIRE

This questionnaire is designed to assist the staff who will be taking care of you. It will help us to learn more about your health. Please fill it out as completely as possible and return it to the reception desk.

Name: _____ Age:_____ Sex: ☐ Male ☐ Female

Height: _____ Weight:_____ Occupation: _____

Please leave the number you can be reached the night before surgery: _____

Referring Surgeon:_____ Type of operation:_____ Date of Surgery:_____

Have you been a patient in this pre-operative anesthesia clinic in the past 3 months? ☐ Yes ☐ No

What kind of physical exercise do you do? (i.e., walk, run, bike, etc. or none)_____

Previous Surgery:

Year of Surgery	Type of Operation	General or Local (were you put to sleep?)	Problem(s) Complications	Explain
1._____		☐ Yes ☐ No	☐ Yes ☐ No	_____
2._____		☐ Yes ☐ No	☐ Yes ☐ No	_____
3._____		☐ Yes ☐ No	☐ Yes ☐ No	_____
4._____		☐ Yes ☐ No	☐ Yes ☐ No	_____

Have you ever been hospitalized for an illness not requiring surgery:

1._____

2._____

3._____

Do you **have** or **have you ever** had any of these problems: (*Please circle*)

1. Heart problems of any kind
2. Stroke
3. Kidney or bladder problems
4. Liver problems or hepatitis
5. High blood pressure
6. Diabetes
7. Bleeding problem
8. Cancer
9. Seizure or epilepsy
10. Rheumatic fever
11. Rheumatoid arthritis
12. Lung problem (e.g., pneumonia, emphysema, asthma)
13. Blood transfusion
14. Tuberculosis (TB)
15. Thyroid disease (or problems)
16. Gastroesophageal Reflux disease/ Hiatial hernia
17. Sleep Anea
18. Date of last menstrual period
19. Other:_____

_____

_____

Please name any medicines that you are presently taking; include ***all*** prescription and non-prescription drugs (even aspirin):

Name of medication **Dosage (amount)** **Number of times taken each day**

1._____

2._____

3._____

Are you allergic to, or have you had unusual reactions to medications, adhesive tape, foods or latex? Please list the items and the type of reaction you experienced.

_____

_____

Have you taken steroids such as prednisone or cortisone? ☐ Yes ☐ No

If so, when? _____

Do you have any of the following: (*Please circle*)

false teeth, capped teeth, loose teeth, braces, chipped teeth

or teeth that need dental care, specify _____

Have you or any of your close relatives had problems or complications with anesthesia? ☐ Yes ☐ No

If so, what? _____

Did your doctor ask you to donate your own blood for surgery? ☐ Yes ☐ No How many units? _____

At the present time, do you have? (*Please check appropriate boxes*)

☐ chest pain
☐ blackouts or periods of dizziness
☐ palpitations or irregular heart beats
☐ pain in your legs with exercise
☐ ankle swelling
☐ shortness of breath at night
☐ shortness of breath while walking up one flight of stairs
☐ chronic cough or sputum (phlegm)
☐ blood in your sputum
☐ black or tarry stools, diarrhea
☐ frequent nausea and vomiting
☐ temporary loss or blurring of vision
☐ temporary weakness of one or more limbs
☐ facial weakness, numbness
☐ burning with urination or frequent urination
☐ arthritis or severe joint pains
☐ back pain or neck pain
☐ excessive bleeding following minor cuts or dental surgery
☐ recent weight loss
☐ difficulty walking
☐ pregnancy
☐ acid reflex symptoms
☐ heart murmur

Have you had any problems in the last two weeks with: (*Please circle*)

A “cold,” “flu,” bronchitis, laryngitis, sore throat, fever

Have you ever smoked? ☐ Yes ☐ No If yes, at worst, how many packs per day? _____

How many years? _____ If you quit, when? _____

Do you drink alcoholic beverages? ☐ Yes ☐ No How often?_____ How much?_____

Do you use “recreational” or illegal drugs? ☐ Yes ☐ No Type_____

Questions for anesthesiologist:

1._____

2._____

3._____