AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

Pre-Anesthesia Questionnaire

The information you supply below assists in the development of your anesthesia care plan. Please complete this questionnaire accurately and completely.

Patient Name _____

Age _____ **Weight** _____ **Height** _____ **Date** _____

Allergies _____

_____

Current Medications – Prescription and Non-Prescription
(*include all over-the-counter medications; herbal supplements; complementary or alternative medicines*)

_____

_____

Prior Operations _____

_____

Your responses to the following questions will help us determine and provide the anesthetic that is best for you.

Yes	No	Question
[ ]	[ ]	Have you recently had a cold or the flu?
[ ]	[ ]	Are you allergic to latex (rubber) products?
[ ]	[ ]	Have you experienced chest pain?
[ ]	[ ]	Do you have a heart condition?
[ ]	[ ]	Do you have hypertension (high blood pressure)?
[ ]	[ ]	Do you experience shortness of breath?
[ ]	[ ]	Do you have asthma, bronchitis, or any other breathing problem?
[ ]	[ ]	Do you (or did you) smoke? **IF YES:** Packs/day _____ Number of years _____ Date you quit _____
[ ]	[ ]	Do you consume alcohol? **IF YES:** Drinks/week _____
[ ]	[ ]	Do you take, or have you taken, recreational drugs?
[ ]	[ ]	Have you taken cortisone (steroids) in the last six months?

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Pre-Anesthesia Questionnaire

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Yes	No	Question
[ ]	[ ]	Do you take any nonsteroidal, anti-inflammatory drugs (NSAIDs)?
[ ]	[ ]	Do you take herbal supplements, or complementary or alternative medicines? **IF YES:** How recently? _____
[ ]	[ ]	Do you have diabetes?
[ ]	[ ]	Have you had hepatitis, liver disease, or jaundice?
[ ]	[ ]	Do you have a thyroid condition?
[ ]	[ ]	Do you have, or have you ever had, kidney disease?
[ ]	[ ]	Do you have ulcers or other stomach disorders?
[ ]	[ ]	Do you have a hiatal hernia?
[ ]	[ ]	Do you have back or neck pain?
[ ]	[ ]	Do you have numbness, weakness, or paralysis of your extremities?
[ ]	[ ]	Do you have any muscle or nerve disease?
[ ]	[ ]	Do you, or any of your family, have sickle cell trait?
[ ]	[ ]	Have you, or any blood relatives, had difficulties with anesthesia?
[ ]	[ ]	Do you have bleeding problems?
[ ]	[ ]	Do you have loose, chipped, or false teeth? Bridgework? Oral piercings (such as studs or rings) in your tongue or lip?
[ ]	[ ]	Do you wear contact lenses?
[ ]	[ ]	Have you ever received a blood transfusion?
[ ]	[ ]	(Women) Are you pregnant? **IF YES:** Due date _____
[ ]	[ ]	(Men) Do you take, or have you taken, Viagra, Cialis, or other erectile dysfunction medicines?