Coral Desert
SURGERY CENTER
1490 E. Foremaster Dr. Bldg. C, St. George Ut. 84790 (435) 674-5230 Fax (435) 674-5231

ANESTHESIA QUESTIONNAIRE

Patient Name:			
Age:	Height: Ft. In.	Weight:	Primary Care Physician:

Y	N	SPECIAL CONSIDERATIONS
		COMMUNICATION PROBLEMS HEARING / VISION
		PHYSICAL LIMITATIONS?
		LATEX ALLERGIES: ☐ NONE
		MEDICATION ALLERGIES: ☐ NONE
		FOOD / OTHERS ALLERGIES: ☐ NONE

I HAVE DISCUSSED WITH MY SURGEON;
THE NECESSITY AND APPROPRIATENESS OF THE PROPOSED SURGERY AS WELL AS ALTERNATIVE TREATMENTS.

☐ YES ☐ NO

COMMENTS:_____

LIST ALL CURRENT AND RECENT MEDICATIONS or ATTACH SEPARATE SHEET
(INCLUDE PRESCRIPTIONS, EYE DROPS, & OVER-THE-COUNTER MEDS / VITAMINS AND THE DOSAGE)

_____ _____ _____
_____ _____ _____
_____ _____ _____

LIST PREVIOUS HOSPITALIZATION OR OPERATIONS
(INDICATE APPROXIMATE YEAR)

_____ _____ _____
_____ _____ _____

** HAVE YOU HAD A BAD REACTION TO ANESTHESIA ☐YES ☐NO

**HAS A BLOOD RELATIVE HAD A BAD REACTION TO ANESTHESIA ☐YES ☐NO

DO YOU HAVE or HAVE YOU HAD	Y	N
DIABETES (Controlled by: Diet, Pills, or Insulin)		
HYPOGLYCEMIA (Low Blood Sugar)		
HEART PROBLEMS (Rheumatic Fever, Murmur, Chest Pain, Heart Attack, Irregular heart Beat, EKG Changes, Angina, Ankle Swelling, Valve Replacement)		
THYROID PROBLEMS		
BLOOD CLOTS, TRANSFUSION PROBLEMS		
BLEEDING TENDENCY (Hemophilia)		
HIGH BLOOD PRESSURE		
STROKE (Weakness or Numbness on one side, Difficulty Speaking, Loss of Vision)		
SEIZURES (Epilepsy, Convulsions, Blackouts)		
SEVERE HEADACHES		
LUNG PROBLEMS (Asthma, Chronic Cough, Pneumonia, Wheezing, Shortness of Breath, Emphysema, Abnormal chest X-ray)		
TUBERCULOSIS / TB		
SLEEP APNEA (Breathing Interruption During Sleep or on Oxygen)		
LIVER PROBLEMS (Jaundice, Hepatitis)		
KIDNEY, BLADDER, OR PROSTATE PROBLEMS (Infections)		
STOMACH PROBLEMS (Ulcer, Hiatal Hernia, Reflux, Heartburn)		
BOWEL PROBLEMS (Irritable Bowl, Diverticulosis)		
BACK, NECK, OR BROKEN BONES IN SPINE (Strain, Disc Problems, Numbness, or Tingling of Hands)		
ARE YOU RECEIVING TREATMENT FOR GLAUCOMA		
IMMUNOCOMPROMISED (HIV, ORGAN TRANSPLANT)		
DIFFICULTY OPENING MOUTH (TMJ)		
ARTHRITIS / RESTRICTIONS IN MOVEMENT		
MUSCLE DISORDERS (MD, Myasthenia Gravis)		
CANCER		
MENTAL HEALTH ISSUES / PHOBIAS		
SKIN DISORDERS (Eczema)		
OTHER MEDICAL PROBLEMS / PARKINSONS DISEASE		

	Y	N
ANY ILLNESS, COLD, COUGH, OR FEVER IN THE LAST WEEK?		
ANY RECENT EXPOSURE TO COMMUNICABLE DISEASES?		
(FEMALES) IS THERE A POSSIBILITY YOU ARE PREGNANT? LAST MENSTRUAL PERIOD: _____		
DO YOU HAVE A HISTORY OF SMOKING? PACKS PER DAY? _____ DATE QUIT? _____		
DO YOU DRINK ALCOHOLIC BEVERAGES? HOW OFTEN? _____ HOW MUCH? _____		
DO YOU HAVE A HISTORY OF OR ARE YOU TAKING ANY RECREATIONAL DRUGS?		
DO YOU HAVE ANY OF THE FOLLOWING ☐BRACES ☐FALSE TEETH ☐BRIDGES ☐RETAINERS ☐LOOSE TEETH ☐CAPPED TEETH ☐CHIPPED TEETH		
DO YOU WEAR CONTACT LENSES?		
ARE THERE ANY PAIN MEDICATIONS YOU CAN NOT TAKE?		
DO YOU HAVE AN ADVANCED DIRECTIVE OR LIVING WILL? (If yes please bring a copy with you)		
WOULD YOU LIKE TO DISCUSS ANY CONCERNS OR FEARS YOU MIGHT HAVE REGARDING THIS PROCEDURE?		
HAVE YOU MADE ARRANGEMENTS FOR ASSISTANCE AFTER YOUR SURGERY?		
DO YOU NEED A RELEASE FOR WORK OR SCHOOL?		
IF THE PATIENT IS A CHILD		
WAS THE CHILD PREMATURE?		
ANY BIRTH DEFECTS OR DEVELOPMENTAL PROBLEMS?		
ANY IMMUNIZATION PROBLEMS OR DELAYS?		
ANY HISTORY OF HOLDING BREATH, CROUP, OR BREATHING PROBLEMS		
COMMENTS:		

PATIENT / SO
SIGNATURE X _____

PATIENT STICKER