

ANESTHESIA PATIENT HEALTH QUESTIONNAIRE

Patient's Name:		Age:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Height:	Weight:
Surgeon:	Procedure:			Date:	Time:

Please fill in the following details. Attach a list if more space is needed.

List all the prescription, over the counter **medicines or herbal preparations** you take. **Do not take medicines**

Medicines/Dose and Frequency (if known)	4	8
1	5	9
2	6	10
3	7	11

List all your **allergies** or untoward reactions to Medicines, Food or Substances. Describe the **reaction**. **No known allergies**

Medicines, Food or Substances (Reaction)	3	6
1	4	7
2	5	8

Check Specific Allergies: Latex rubber Shellfish Iodine Fish Egg products

List all the **surgeries** you have had. (Any of the surgeries at Sutter Roseville Medical Center? Yes No) **Never had surgery**

Surgical Procedure	Year	4	5	6	7
1					
2					
3					

Please answer all the following questions (both pages) about your health. If the answer is "Yes" or "Unsure", then check any other conditions below the question that apply to you. If the answer is "No" go to the next question.

1. Any difficulties or complications with **previous anesthesia or surgery?** **Yes** **No** **Unsure**

- | | | |
|--|--|---|
| <input type="checkbox"/> Severe nausea and vomiting | <input type="checkbox"/> Awareness while under anesthesia | <input type="checkbox"/> Difficult intubation (insertion of breathing tube) |
| <input type="checkbox"/> Difficulty waking up | <input type="checkbox"/> Untoward or Allergic Reaction | <input type="checkbox"/> Malignant hyperthermia (you or family) |
| <input type="checkbox"/> Other (<i>describe</i>) _____ | <input type="checkbox"/> Excessive bleeding during surgery | <input type="checkbox"/> Blood relative had major complication |

2. Have you ever had **heart, circulation or blood pressure problems?** **Yes** **No** **Unsure**

- | | | |
|---|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart attack (Infarction) | <input type="checkbox"/> Irregular heart beat or palpitations |
| <input type="checkbox"/> Angina or chest/arm/jaw pain | <input type="checkbox"/> Congestive heart failure ("fluid in the lungs") | <input type="checkbox"/> Pacemaker or defibrillator |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Heart murmur / Heart valve problem | <input type="checkbox"/> Born with a heart problem |
| <input type="checkbox"/> Leg or neck artery blockage | <input type="checkbox"/> Other heart conditions (<i>describe</i>) _____ | |

3. Are you able to climb **two flights of stairs without stopping?** **Yes** **No** **Unsure**

4. Have you ever had specialized **heart test or a heart procedure?** **Yes** **No** **Unsure**

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> EKG | <input type="checkbox"/> Stress test | <input type="checkbox"/> Echocardiogram (ultrasound) | <input type="checkbox"/> Heart nuclear scan |
| <input type="checkbox"/> Holter monitor | <input type="checkbox"/> Heart cath. (angiogram) | <input type="checkbox"/> Angioplasty, stent or "balloon" procedure | |
| <input type="checkbox"/> Other heart test or procedure _____ • Have you been told any of these tests were abnormal? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |

5. Have you ever had **breathing problems or a lung condition?** **Yes** **No** **Unsure**

- | | | | | |
|---|---|--|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Recent cold, sore throat (last 2 weeks) |
| <input type="checkbox"/> Emphysema or COPD | <input type="checkbox"/> Sleep apnea or very loud snoring | <input type="checkbox"/> Use oxygen / CPAP | <input type="checkbox"/> Shortness of breath | |
| <input type="checkbox"/> History of Pneumonia | <input type="checkbox"/> Other lung or breathing problems (<i>describe</i>) _____ | | | |

PLEASE COMPLETE PAGE 2 OF THE QUESTIONNAIRE



Anesthesia Patient Health Questionnaire

Patient Identification

6. Have you ever had a **brain, nerve, muscle or mental** health condition? Yes No Unsure

Stroke TIA ("mini-stroke") Seizures or epilepsy Paralysis Numbness or weakness (hands/feet/face)
 Multiple sclerosis Neuropathy Tremors Parkinsonism Loss of bladder or bowel control
 Muscle disease Headache/Migraines Anxiety (severe) Depression Other (*describe*): _____

7. Have you ever had any **liver or digestive** problems? Yes No Unsure

Ulcer Hiatal hernia or Reflux disease (GERD) Gall Bladder problems Hepatitis Yellow Jaundice
 Cirrhosis Difficulty in swallowing Unintentional weight loss Other (*describe*): _____

8. Have you ever had a **kidney or prostate** condition? Yes No Unsure

Bladder or kidney infection Kidney stones Diminished kidney function/Kidney failure
 Blood or peritoneal dialysis Prostate enlargement or cancer Other (*describe*): _____

9. Have you ever had a **blood or clotting** disorder? Yes No Unsure

Anemia History of blood transfusion Blood clotting disorder (*Abnormal bleeding*)
 Sickle cell trait or disease Transfusion reaction Bruising without reason
 Blood clots in legs or lungs Use blood thinners (anticoagulants) Other (*describe*): _____

10. Have you ever had **diabetes, thyroid or endocrine** disorder? Yes No Unsure

Diabetes treated with diet alone pills Insulin History of diabetic coma Hypoglycemia
 Over or under active thyroid Prednisone or steroid use Other (*describe*): _____

11. Have you ever had **arthritis, spine, joint or connective tissue** problems? Yes No Unsure

Degenerative arthritis Osteoporosis Spine problems: neck upper back lower back
 Rheumatoid arthritis TMJ arthritis/ Difficulty in opening mouth Neck stiffness or pain with neck movement
 Fibromyalgia/ Chronic fatigue Fractures Other (*describe*): _____

12. **For women:** Is there a **possibility** that you could be **pregnant now**? Yes No Unsure

Date of last menstrual period (if applicable): _____ If pregnant, weeks of pregnancy: _____

13. Infants & Children

Premature Birth Recent (within 3 weeks) runny nose, fever, cough, wheezing Other: _____

14. Did you ever or Do you use **tobacco**, drink **alcohol** or use **Illicit Drugs**? Yes No Unsure

Cigarette smoking _____ packs per day _____ years of smoking If quit smoking when? Year: _____
 Cigar or Pipe smoking Alcohol _____ drinks per week Treated for alcoholism in past
 Marijuana use Cocaine Methamphetamine Other recreational drug use

15. Other **medical conditions and information**? (Please check the appropriate)

Hearing loss Vision loss or blindness Glaucoma Hearing aids Contact lenses
 Dental bridge Dentures Loose teeth Capped teeth Tongue piercing or other body piercing

- Did you donate blood in preparation for this surgery? Yes No
- Do you have personal or religious objections to receiving a blood product transfusion if necessary? Yes No
- Except for planned surgeries, have you been hospitalized or gone to the emergency room in last twelve months?
 Yes No
- Do you have any skin condition? Open wound Abrasions Rashes Bruises Other _____
- Have you had EKG in last 6 months? Yes No
- Have you had Chest X-ray in last 12 months? Yes No

Any other **medical conditions or concerns about anesthesia**, you wish to inform anesthesiologist? (*Please describe*)

Your anesthesiologist will discuss the type of anesthesia and the risks associated with anesthesia. All anesthetic procedures have risks. Those risks could be as minor as nausea & vomiting and dental injury or as major as life threatening complications.

Patient Identification

I have read and answered above questions truthfully.

Relation to the Patient: Self Parent

Spouse Other

Signature: _____ **Date:** _____