ANESTHESIA PATIENT HEALTH QUESTIONNAIRE

Patient's Name:	Age:	Gender: M 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	
1		5	
2		6	
3		7	

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**

☐ Severe nausea and vomiting ☐ Awareness while under anesthesia ☐ Difficult intubation (insertion of breathing tube)
☐ Difficulty waking up ☐ Untoward or Allergic Reaction ☐ Malignant hyperthermia (you or family)
☐ Other (*describe*)_____ ☐ Excessive bleeding during surgery ☐ Blood relative had major complication

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

☐ High blood pressure ☐ Heart attack (Infarction) ☐ Irregular heart beat or palpitations
☐ Angina or chest/arm/jaw pain ☐ Congestive heart failure ("fluid in the lungs") ☐ Pacemaker or defibrillator
☐ High cholesterol ☐ Heart murmur / Heart valve problem ☐ Born with a heart problem
☐ Leg or neck artery blockage ☐ Other heart conditions (*describe*) _____

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**

☐ EKG ☐ Stress test ☐ Echocardiogram (ultrasound) ☐ Heart nuclear scan
☐ Holter monitor ☐ Heart cath. (angiogram) ☐ Angioplasty, stent or "balloon" procedure
☐ Other heart test or procedure_____ • Have you been told any of these tests were abnormal? ☐ Yes ☐ No

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

☐ Asthma ☐ Hay fever ☐ Chronic cough ☐ Bronchitis ☐ Recent cold, sore throat (last 2 weeks)
☐ Emphysema or COPD ☐ Sleep apnea or very loud snoring ☐ Use oxygen / CPAP ☐ Shortness of breath
☐ History of Pneumonia ☐ Other lung or breathing problems (*describe*) _____

PLEASE COMPLETE **PAGE 2** OF THE QUESTIONNAIRE&

Sutter Roseville Medical Center
A Sutter Health Affiliate

Anesthesia Patient Health Questionnaire

Patient Identification

50-7430-0527 (11/12/08)

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:_____