

Bloomington/Normal Healthcare Surgery Center
Pre-Anesthesia/Surgery Questionnaire

Date of Surgery: _____
Name: _____ Birth Date: _____ Actual
Weight: _____
Surgeon: _____ Age: _____
Height: _____

1. Allergies (Include medications, foods, environment, balloons, and/or latex allergies). Name and describe reactions.

If no allergies check here.

2. Any previous surgeries (List type and year):

Have you ever had a problem with anesthetic? Yes No

If yes, what happened? _____

Has anyone in your family ever had a problem with an anesthetic? Yes No

3. Have you had within the last month any of the following?

	YES	NO		YES	NO
Cold	<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>
Flu	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Congested Cough	<input type="checkbox"/>	<input type="checkbox"/>	Injury	<input type="checkbox"/>	<input type="checkbox"/>
Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>			

If yes, explain: _____

4. Do you use tobacco? Yes No Quit When? _____
What _____ Packs per day? _____ How many years? _____

Do you drink alcohol? Yes No
If yes, amount per day? _____ Week? _____ Month? _____

Do you use street drugs? Yes No

If yes, drug name: _____ Last used: _____

5. Check any of the following that you have:

Glasses Contact Lenses Hearing Aid: L: R:
 Dentures: Upper Lower Capped Teeth Partial/Bridge: Upper Lower
 Walker Cane Crutches Wheelchair
 Prosthesis: _____ Implants: _____

6. Are there any religious or cultural practices that the staff needs to be aware of while here?
 Yes No If yes, list: _____

7. Do you follow a certain diet at home? Yes No If yes, please explain: _____

8. Answer if patient is 16 or under:
 Is there any developmental delay? Yes No
 If yes, please explain: _____

Childhood immunizations up to date? Yes No
 If no, please explain: _____

Was child born on at: Full-term Pre-mature by: _____ weeks

Do you have a medical history of (please check in appropriate column):

9.	Yes	No	Comments		Yes	No	Comments
Heart attack (date)	<input type="checkbox"/>	<input type="checkbox"/>		Bowel problems	<input type="checkbox"/>	<input type="checkbox"/>	
Mitral Valve Prolapse/ murmur	<input type="checkbox"/>	<input type="checkbox"/>		Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>		Back problems/back pain	<input type="checkbox"/>	<input type="checkbox"/>	
Fast Heart Rate	<input type="checkbox"/>	<input type="checkbox"/>		Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>		Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>		Seizure disorder/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	
Pain in Chest/Arms/Shoulder	<input type="checkbox"/>	<input type="checkbox"/>		Motion Sickness	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>		Headache	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		Parkinson's	<input type="checkbox"/>	<input type="checkbox"/>	

Emphysema				Stroke (date)			
Bronchitis				Myasthenia Gravis			
Hay fever				Depression			
Tuberculosis				Anxiety			
Chronic Cough				Mental Disorder			
Ulcers				Bleeding Disorder			
Liver Disease				Diabetes			
Jaundice/Hepatitis				Glaucoma			
Hiatal Hernia				Thyroid Problem (low/high)			
Kidney Disease				AIDS/HIV			
Kidney Stone				Cancer (type) Treatment:			
Dialysis				Carrier Infectious Disease			
Frequent Urination				Are you pregnant?			
Incontinence				Last Menstrual Period Date:			
Prostate Problems				Mental or physical handicaps			

10. Medications: List all medications currently taking below: (Include prescriptions, non-prescription drugs, and herbals) **If taking no medications, check here**

Surgicenter Use Only Below

Surgical Procedure: _____ Date: _____

Reviewed by: _____

Pre-op Phone Call: No Health Changes

_____ RN Signature Date

Reviewing Physician's Signature Date

Anesthesia Notes:

Heart: WNL

Other _____

Lungs: clear to auscultation

Other _____

Airway: _____

EKG: WNL

Other

CSR: Other

Labs:

Anesthesia Type: General Regional MAC Local
ASA Physician Status 1 2 3 4 5 E

Signature

Date (Day of Surgery)

Physician's