CGH MEDICAL CENTER
STERLING, IL
ANESTHESIA
PATIENT QUESTIONNAIRE

Patient's Name____ Age______ Sex______
Planned Operation____ Date of Surgery_________
Surgeon_________________ Primary Physician_________________ Previous Admission: ☐ Yes ☐ No
Heart Doctor: Maxwell/ Kurian/ Gopal / Yousseff / Other _____________Last Visit Date___/___/___
Your height(in) __________________________ Your Weight (lb) __________________________

I. SURGICAL HISTORY: List **all major surgeries** requiring anesthesia services and dates:

____ ____
____ ____
____ ____

II. MEDICATION HISTORY:

1. List any **Allergies** or **Side Effects** to medications and explain type of reaction:

____ ____
____ ____
____ ____

☐ Yes ☐ No **2**. Do you take appetite suppressants? Name _______________ Last dose taken: ___/___/___

☐ Yes ☐ No Do you take sedative/anxiety pills? Name ______________ Average # of pills per day_______

☐ Yes ☐ No Do you take strong pain pills like vicodin or morphine? List name of medication, dose and average number of pills taken per day.

__________________________ __________________________ __________________________
__________________________ __________________________ __________________________

☐ Yes ☐ No Have you taken Plavix, Aggrenox, Coumadin or Lovenox in the last 7 days? Last dose: __/__/_

☐ Yes ☐ No Have you taken oral steroids (prednisone or cortisone) in the last year?

3. List **All Medications (not listed above)** you have taken in the last month (include OVER THE COUNTER drugs, inhalers,herbals dietary supplements, vitamins) or attach a current medication list:

____________________________ ____________________________ ____________________________
____________________________ ____________________________ ____________________________
____________________________ ____________________________ ____________________________

☐ Yes ☐ No **4.** Have you had anesthetic related problems (check all that apply)

☐ Severe nausea/vomiting ☐ Difficult breathing tube placement ☐ Difficult spinal

☐ Malignant hyperthermia ☐ Prolonged drowsiness ☐ Breathing difficulties

☐ Motion sickness

12/10,2/11

CGH MEDICAL CENTER
STERLING, IL
ANESTHESIA
PATIENT QUESTIONNAIRE

III. MEDICAL HISTORY: Please check **YES** or **NO** and **CIRCLE specific problems**	**YES**	**NO**
Have you ever smoked? (# of____packs/day for _____years)…………………………..	☐	☐
Do you still smoke? …………………………………………………………..	☐	☐
Do you consume alcoholic beverages? When was your last drink? ___/___/___ ……….	☐	☐
If so how many drinks per week______		
Do you use any illegal drugs?………………………………………………………….	☐	☐
Can you currently walk up 1 flight of stairs or 2 blocks without stopping? ……………..	☐	☐
Have you had any problems with your heart? ………………………………….. …….	☐	☐
(chest pain, heart attack, abnormal ECG, skipped beats, heart murmur, palpitation, heart failure)		
Do you require antibiotics before routine dental care? …………………………………..	☐	☐
Do you have or have you ever had high blood pressure? ………………………………..	☐	☐
Have you had any problems with your lungs or your chest?		
(shortness of breath, emphysema, bronchitis, asthma, tuberculosis, abnormal chest X-ray) ……..	☐	☐
Are you ill or were you recently (within last 2 weeks) ill with a cold, fever, chills flu or productive cough? Describe recent changes________________________________	☐	☐
Have you or anyone in your family had serious bleeding problems? ……………………	☐	☐
(prolonged bleeding from nosebleed, gums, tooth extractions or surgery)		
Have you had any problems with your blood? …………………………………………..	☐	☐
(anemia, leukemia, sickle cell disease, blood clots, transfusions?)		
If yes, when? ____		
Have you ever had problems with:		
• Liver (cirrhosis, hepatitis, jaundice)? ………………………………………....	☐	☐
• Kidney (stones, failure, dialysis)? …………………………………………………..	☐	☐
• Digestive system (frequent heartburn, hiatus hernia, stomach ulcer)? …………..	☐	☐
• Back, neck or jaw (TMJ, rheumatoid arthritis, sciatica, chronic back pain)? ……….	☐	☐
• Seizures, epilepsy or fits? …………………………………………………………..	☐	☐
• Stroke, facial, leg or arm weakness difficulty speaking? ………………………..	☐	☐
• Cramping pain in your legs with walking? ………………………………………	☐	☐
• Problems with hearing, vision or memory? ……………………………………...	☐	☐
• Diabetes (Type1, Type2, using insulin)? ………………………………………....	☐	☐
• Thyroid or parathyroid disease? ……………………………………………….	☐	☐
• Treated for cancer? (chemotherapy or radiation therapy) ………………………..	☐	☐
Do you have any chipped or loose teeth, dentures, caps, bridgework, braces, problems opening your mouth, swallowing, choking or hoarseness?	☐	☐
Do your physical abilities limit your daily activities? ……………………………………	☐	☐
Do you snore, or have you been suspected or tested positive for sleep apnea? . . . . . …...	☐	☐

Women: Date of last menstrual period___/__/__Tubal Ligation or Hysterectomy ___/___/___

Please list any medical illnesses not noted above____

Additional comments or questions for anesthesia staff ____________________________________

____

12/10,2/11

____

Patient Signature and Date