Straith Clinic, P.C.
Health Questionnaire/Pre-Anesthesia Evaluation

Name: ______________________________ Age: _____ Male___ Female ___

Height ______________ Weight ________________ BMI_________ (RN use only)

Family Doctor: Name_________________________ City: ____________________ Phone (_____) ________________

Emergency contact: Name: ____ Phone (_____) ________________

Pre-Operative Health History

	yes	no
chronic cough or lung problems	___	___
shortness of breath at rest	___	___
shortness of breath with exercise	___	___
recent cold/bronchitis/pneumonia	___	___
history of asthma or wheezing	___	___
history of emphysema	___	___
history of tuberculosis	___	___
history of sleep apnea/CPAP	___	___
history of snoring	___	___
high blood pressure	___	___
for how many years? _____________		
heart attack; date __________________	___	___
heart failure; date _________________	___	___
irregular heart beat; date ____________	___	___
chest discomfort/tightness with exercise/ angina	___	___
mitral valve prolapse	___	___
heart murmur	___	___
stroke	___	___
TIA	___	___
Multiple Sclerosis	___	___
weakness/paralysis	___	___
epilepsy/seizures	___	___
date of last seizure ______________		
chronic back problems	___	___
excessive bleeding from surgery	___	___
history of anemia (low blood count)	___	___
diabetes (type I or II ? ______)	___	___
since _______________		
hypoglycemia	___	___
liver disease/jaundice	___	___

	yes	no
hepatitis (A, B, or C ? ______)	___	___
kidney disorder	___	___
thyroid disease	___	___
stomach ulcer	___	___
chronic heartburn/gastric reflux/hiatal hernia	___	___
could you be pregnant?	___	___
last menstrual period/date ______________		
dentures/bridges/caps	___	___
skin problems	___	___
circulation problems/swelling of ankles	___	___
blood clots	___	___
hard of hearing	___	___
wear glasses/contact lenses	___	___
problems walking	___	___
chemotherapy	___	___
compromised immune system/AIDS/HIV	___	___
history of motion sickness	___	___
problems with chewing/swallowing	___	___
emotional problems	___	___
what ? ___________________________		
when ? ___________________________		
substance abuse	___	___
what ?___________________________		
when ?___________________________		
addictive drugs	___	___
what ?___________________________		
when ?___________________________		
alcoholic drinks (_____ per week)	___	___
smoking	___	___
_____ packs per day for _____ years		
date stopped smoking ____________		

Have you had:

	yes	no	if yes, when/where/doctor's name
an exam by a cardiologist	___	___	____________________________
heart catheterization	___	___	____________________________
exercise stress test	___	___	____________________________
ultrasound of heart (echocardiogram)	___	___	____________________________
pacemaker	___	___	____________________________

Please list all previous hospitalizations (including surgery, childbirth, medical illness, bariatic)

date (approx year)	reason	place (hospital or city)

OVER →

Allergies

	yes	no	reaction
latex	___	___	________
any food	___	___	________
adhesive tape	___	___	________
iodine on your skin	___	___	________
any medications	___	___	**if yes to any medication, list medication and reaction below**

medication	reaction

Please list all prescription and non-prescription medications you are presently taking, including dosage and frequency. Please include non-prescription medications such as iron, aspirin, antacid, laxatives, eye drops, vitamins, diet pills, and herbal supplements.

medication	dose	times per day	RN use only

	yes	no
Have you had any problems with anesthesia ?	___	___
If yes, please explain ________		
Is there any family history of problems with anesthesia ?	___	___
If yes, please explain________		
Have you had any problems with previous surgery ?	___	___
If yes, please explain________		
Do you have a history of chronic pain ?	___	___
If yes, please explain________		

On a scale of 1 to 10, check the corresponding number of your pain:

0____ 1____ 2____ 3____ 4____ 5____ 6___ 7__ 8____ 9____ 10____

no pain — moderate pain — worst possible pain

Are there any personal or religious reasons you would refuse a blood transfusion ? ___ yes ___ no

Reason ________

Comments: ________

____

____

________ Signature of patient

________ Date

REVIEWED BY:

________ Signature

________ Date