

MONTGOMERY SURGERY CENTER PRE-ANESTHESIA QUESTIONNAIRE

46 WEST GUDE DRIVE

ROCKVILLE, MARYLAND 20850

PHONE: (301) 424-6901 FAX: (301) 309-6863

OFFICE USE ONLY

SURGEON: _____ **PROCEDURE DATE:** _____ **TIME:** _____

TO BE COMPLETED BY PATIENT PLEASE ANSWER ALL QUESTIONS ON PAGE 1 AND 2; FAX OR MAIL TO MSC

NAME: _____ **PHONE #:** _____ **CELL #:** _____ **DATE:** _____

AGE: _____ **HEIGHT:** _____ **WEIGHT:** _____ **SEX:** MALE FEMALE

COMPLETED BY: _____ **RELATIONSHIP TO PATIENT:** SELF OTHER _____

1. DO YOU HAVE ANY ALLERGIES TO MEDICATION – FOOD – LATEX? YES (LIST BELOW) NO UNSURE

ALLERGY	REACTION

ALLERGY	REACTION

2. HAVE YOU EVER HAD SURGERY BEFORE? YES (LIST BELOW) NO UNSURE

SURGERY	DATE

SURGERY	DATE

3. DO YOU TAKE PRESCRIPTION MEDICINES? (PLEASE LIST, USE SEPARATE SHEET IF NEEDED) YES NO UNSURE

1.	4.	7.
2.	5.	8.
3.	6.	9.

4. DO YOU TAKE OVER-THE-COUNTER OR HERBAL MEDICINES, OR VITAMINS YES NO UNSURE

1.	3.	5.
2.	4.	6.

5. HAVE YOU EVER HAD PROBLEMS WITH ANESTHESIA BEFORE? YES NO UNSURE

- difficulty breathing tube insertion
- nausea or vomiting
- other (describe) _____
- malignant hyperthermia - (you or family member)
- family member had major anesthesia problem

6. HAVE YOU EVER HAD A HEART CONDITION, PROCEDURE OR HIGH BLOOD PRESSURE? YES NO UNSURE

- heart attack ___/___/___
- chest pain
- abnormal ekg
- congestive heart failure [fluid on the lung(s)]
- high bloodpressure
- heart murmur
- heart valve problem
- congenital heart disease
- other (describe) _____
- irregular heart beat/palpatations
- heart or bypass surgery
- angioplasty-stent-balloon procedure
- pacemaker or defibrillator

7. HAVE YOU HAD BREATHING PROBLEMS OR A LUNG CONDITION? YES NO UNSURE

- asthma
- emphysema or copd
- chronic cough
- loud snoring
- recent cold or fever ___/___/___
- recent respiratory infection
- recent pneumonia (last 2 months)
- home oxygen
- shortness of breath when flat
- cpap or bipap
- sleep apnea (stop breathing when asleep)
- other _____

8. DO YOU BECOME SHORT OF BREATH WITH ANY OF THE ACTIVITIES LISTED BELOW?

- CLIMB FLIGHT OF STAIRS
- WALK UPHILL
- WALK AT A FAST PACE
- HEAVY HOUSEWORK LIFTING/MOVING FURNITURE, SCRUBBING FLOORS?

*DOES YOUR CHILD FATIGUE EASILY OR TURN BLUE WITH FEEDING OR PHYSICAL EXERTION? YES NO UNSURE

PLEASE COMPLETE PAGE 2

9. DO YOU HAVE DIABETES OR A THYROID CONDITION? YES NO UNSURE

- NON INSULIN DEPENDENT DIABETES HYPOTHROID (UNDERACTIVE) OTHER _____
 INSULIN DEPENDENT DIABETES HYPERTHROIDISM (OVERACTIVE) _____

10. DO YOU HAVE A LIVER, KIDNEY OR PROSTATE PROBLEM? YES NO UNSURE

- KIDNEY DISEASE HEPATITIS OR JAUNDICE PROSTATE CANCER
 DIALYSIS CIRRHOSIS OF LIVER ENLARGED PROSTATE

11. DO YOU HAVE A BRAIN, NERVE, MUSCLE AND/OR MENTAL HEALTH CONDITION? YES NO UNSURE

- STROKE OR TIA (MINI STROKE) NUMBNESS OR WEAKNESS MUSCLE DISEASE
 SEIZURES MULTIPLE SCLEROSIS SEVERE ANXIETY
 MIGRAINES DEPRESSION OTHER _____

11. DO YOU HAVE AN ORAL OR DIGESTIVE PROBLEM? YES NO UNSURE

- CHIPPED, LOOSE, FRAGILE TEETH TAKE DIET MEDICATIONS HISTORY OF MOTION SICKNESS
 ACID REFLUX, HEARTBURN, HIATAL HERNIA SEVERE WEIGHT LOSS OTHER _____

12. DO YOU HAVE A BLOOD DISORDER? YES NO UNSURE

- ANEMIA (LOW BLOOD COUNT) ABNORMAL BLEEDING OR BRUISING SICKLE CELL DISEASE
 BLOOD CLOTS OTHER _____

13. DO YOU HAVE ARTHRITIS, SPINE OR JOINT PROBLEMS? YES NO UNSURE

- RHEUMATOID ARTHRITIS TMJ (JAW JOINT PAIN) NECK PAIN
 OSTEOARTHRITIS SPINE PROBLEMS UPPER BACK PAIN
 JOINT REPLACEMENT LOWER BACK (SCIATICA) OTHER _____

14. HAVE YOU EVER BEEN DIAGNOSED WITH CANCER? YES NO UNSURE

- TYPE _____ DATE _____ RADIATION THERAPY DATE _____
 CHEMOTHERAPY (TYPE) _____

15. DO YOU HAVE ANY INFECTIOUS DISEASES? YES NO UNSURE

- HIV POSITIVE AIDS TB (TUBERCULOSIS) OTHER _____

16. HAVE YOU SMOKED CIGARETTES? DO YOU DRINK ALCOHOL OR USE DRUGS? YES NO

- Cigarettes _____ packs/day alcohol _____ drinks/day _____ drinks/week marijuana cocaine
 Other Drugs (Describe) _____

17. WOMEN: IS THERE ANY CHANCE THAT YOU COULD BE PREGNANT? YES NO UNSURE

DATE OF LAST MENSTRUAL PERIOD _____

18. HAVE YOU EVER HAD ANY SPECIALIZED HEART TESTS? YES NO UNSURE

- STRESS TEST: DATE _____ ECHOCARDIOGRAM: DATE _____ HEART CATHETERATION (ANGIOGRAM) DATE _____
 CARDIOLOGIST NAME _____ PHONE # _____

19. HAVE YOU SEEN YOUR DOCTOR OR HAD MEDICAL TESTS IN THE PAST 3 MONTHS? YES NO UNSURE

- BLOOD TESTS EKG CHEST X-RAY OTHER _____
 PRIMARY CARE PHYSICIAN NAME _____ PHONE No.: _____

NURSES NOTES: _____

