# ANESTHESIA CONSULTANTS OF THE UPPER VALLEY, PLLC

## PRE-ANESTHESIA QUESTIONNAIRE

Name: Age: Procedure:

| Please list surgeries you have had: | Allergies: |
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| | Medications: |
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| | | | If yes, please explain further: |
|---|---|---|---|
| Problems with anesthesia in you or family? | Yes | No | |
| Chest pain, angina, heart disease? | Yes | No | |
| Heart rhythm problems? | Yes | No | |
| Heart valve problems, murmur? | Yes | No | |
| Hypertension? | Yes | No | |
| Difficulty opening mouth? | Yes | No | |
| Difficulty lying flat? | Yes | No | |
| Sleep apnea and/or CPAP use? | Yes | No | |
| Neck size > 17 inches | Yes | No | |
| Active smoking? | Yes | No | |
| Home oxygen? | Yes | No | |
| Shortness of breath with activity? | Yes | No | |
| Asthma? | Yes | No | |
| Recent pneumonia or cold with cough? | Yes | No | |
| Acid reflux, GERD, heart burn? | Yes | No | |
| Seizure disorder? | Yes | No | |
| Diabetes / problems with blood sugars? | Yes | No | |
| Kidney problems? | Yes | No | |
| Liver problems? | Yes | No | |
| Bleeding disorders in you or family? | Yes | No | |
| Take anticoagulation medication? | Yes | No | |
| Regular alcohol consumption >2/night? | Yes | No | |
| Recreational drug use? | Yes | No | |
| Could you be pregnant? | Yes | No | |
| Have or had cancer? | Yes | No | |
| Organ transplants? | Yes | No | |
| Chronic pain, take opioids, see a pain specialist? | Yes | No | |
| Birth defect, genetic defect? | Yes | No | |
| Depression, mood disorder, etc? | Yes | No | |
| Anxiety and/or claustrophobia? | Yes | No | |
| Anything additional you would like me to know? | Yes | No | |