Facility_____

Surgery Date _____

PT Phone #_____

Quantum Anesthesia Services LLC

Pre-Anesthesia Questionnaire

Information you supply below assists in the development of your anesthesia care plan

Name _____ DOB _____

Age _____ Height _____ Weight _____ BMI _____

Allergies_____

Please describe reaction to each medication allergy _____

_____

Current Medications (prescription, non-prescription, herbal supplements):

_____

_____

Prior Surgeries/Procedures: _____

Please circle "YES" or "NO" and write additional comments next to each condition

Recent Cold / Flu: **Yes / No** _____

Chest Pain / Angina: **Yes / No** _____

Heart Attack /MI/Congestive Heart Failure / Irregular Heart Beat: **Yes / No** _____

Angioplasty / Stent: **Yes / No**_____

High Blood Pressure: **Yes / No** _____

Asthma / COPD / Emphysema / Shortness of Breath: **Yes / No** _____

Can you walk 1 2 or 3 blocks without getting shortness of breath? **Yes / No** _____

Sleep Apnea /CPAP Machine / Severe Nighttime Snoring: **Yes / No** _____

Liver / Kidney Disease: **Yes / No** _____

Acid Reflux / GERD / Hiatal Hernia: **Yes / No** _____

Stroke / TIA / Seizures: **Yes / No**_____

Paralysis / Muscle Disease / Nerve Disease: **Yes / No** _____

Bleeding Problems / Easy Bruising: **Yes / No** _____

Diabetes (type) / Thyroid Disease: **Yes / No** _____

Smoking: **Yes / No** (packs/day __ how many years __ year quit____)

Alcohol Use: **Yes / No** (how much and how often) _____

Recreational Drugs: **Yes / No** type_____ frequency _____

Substance Dependence Presently or in Past: **Yes/No** (type of substance) _____

Any Unusual Reaction to Anesthesia in Past: **Yes / No** _____

Possibility of Pregnancy: **Yes / No** _____

Any other condition not listed above _____

Any special concerns or questions for anesthesia provider _____

Fax: 773-442-1551 Email: Main1@QuantumAnesthesia.com