



O'Connor Hospital

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(408) 947-2500

ANESTHESIA QUESTIONNAIRE (complete & sign at the end)

Patient Name	Height	Weight
Surgeon		
Regular Doctor		Phone #

If you are going to receive any Sedative Drugs (including General Anesthesia),
YOU MUST HAVE SOMEONE DRIVE YOU HOME.

Name of person who will take you home	Phone #
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List all medications (pills, drops, patches, injections and inhalers) that you currently take. INCLUDE non-prescription items like vitamins, herbal products, and any illegal drugs. Include doses and how often taken.

What medical illnesses do you have? (e.g high blood pressure, diabetes) List all, whether or not they are treated.

ALLERGIES:

Are you allergic to:		
EGGS	Y	N
SEAFOOD	Y	N
SOYBEANS	Y	N
SULFITES	Y	N
LATEX	Y	N

List any other medication or environmental allergies that you have:

List all the operations you have had in the past and dates:

Did you have problems with anesthesia? If so, please specify

1. Has any family member that is related to you ever had a problem with Anesthesia? Including a very high fever.	Y	N	19. Have you lost more than 10 pounds in the last 6 months? Are you trying to lose weight?	Y	N
2. Do you snore when you sleep?	Y	N	20. Have you ever had problems with your thyroid gland?	Y	N
3. Do you have sleep apnea?	Y	N	21. Have you taken a medicine called cortisone or prednisone within the past year? (for any reason)	Y	N
If so, do you use CPAP?	Y	N	Why?		
What CPAP settings?			22. Have you ever had a stroke? (CVA or TIA?)	Y	N
4. Do you have:			When?		
Chipped or loose teeth?	Y	N	Do you have any residual symptoms?	Y	N
Dentures?	Y	N	Describe		
Bridges?	Y	N	23. Have you ever had epilepsy, any type of seizures or passing out?	Y	N
Braces?	Y	N	24. Do you have physical disabilities? (use a cane or walker, have problems moving an arm or leg in a certain way)	Y	N
5. Do you smoke?	Y	N	Describe.		
Have you ever smoked?	Y	N	25. Do you have problems with your neck? Your back?	Y	N
How many packs a day?			26. Have you ever had kidney problems?	Y	N
How many years?			Are you on dialysis (CAPD, cyclor, hemodialysis)?	Y	N
When did you smoke last?			How often?		
6. Do you have problems with breathing?	Y	N	When was your last dialysis?		
Do you have asthma?	Y	N	27. Have you ever been jaundiced (yellow skin)?	Y	N
COPD/emphysema?	Y	N	Have you ever had any type of Hepatitis (A,B,C, other)?	Y	N
Wheezing?	Y	N	Do you have cirrhosis?	Y	N
Seasonal allergies?	Y	N	28. Do you have peptic ulcer disease?	Y	N
7. Do you use inhalers?	Y	N	Gastric reflux (GERD)?	Y	N
8. Do you have a cough?	Y	N	Do you have a hiatal hernia? (part of the stomach is in the chest)	Y	N
9. Have you ever had a chest x-ray that was not normal? (e.g. TB, cancer, COPD)	Y	N	Do you take medicine for any of these?	Y	N
10. When was your last chest x-ray and where?			How often do you have symptoms		
11. When you walk up at least 2 flights of stairs do you become short of breath?	Y	N	29. Could you be pregnant?	Y	N
12. Have you ever had rheumatic fever or been told you had a heart murmur?	Y	N	Date of last period?		
13. Do you take antibiotics before seeing the dentist?	Y	N	May we do a pregnancy test?	Y	N
14. Have you ever had a heart attack?	Y	N	30. Do you have any bleeding tendencies?	Y	N
15. Have you ever had angina or pain in your chest (related to your heart)?	Y	N	If you get a cut, how long does it usually bleed?		
When did you last have chest pain?			31. Do you have any eye problems?	Y	N
What makes the chest pain better? Or worse?			Glaucoma?	Y	N
16. Have you ever had high blood pressure?	Y	N	Cataracts?	Y	N
17. Do you have a history of an irregular heartbeat?	Y	N	Detached retina?	Y	N
18. Do you have diabetes?	Y	N	32. Have you ever been under the care of a psychiatrist or psychologist?	Y	N
How often do you check your sugar?			Do you have claustrophobia?	Y	N
What is your average sugar?			Do you have panic attacks?	Y	N
Do you use Insulin?	Y	N	33. Have you received any organ transplants?	Y	N
Do you have an insulin pump?	Y	N	Which ones?		

This information is true and accurate to the best of my knowledge.

Patient Signature: _____ Date: _____