PRE-ANESTHESIA QUESTIONNAIRE

Ramapo Valley Surgical Center

Name

Physician/Surgeon

Label

Age | **Height** | **Weight**

Please Mark All Boxes	**YES**	**NO**
Recent Cold/Flu		
Asthma/COPD/Emphysema		
Pneumonia/TB		
Chronic Cough		
Nighttime Snoring		
Sleep Apnea/CPAP		
Smoking [ ] Yes [ ] No [ ] Every Day [ ] Some Days [ ] Former [ ] Never		
Rheumatic Fever		
Heart Murmur		
High Blood Pressure		
Low Blood Pressure		
Chest Pain/Angina		
Heart Attack/MI		
Irregular Heart Beat		
Palpitations		
Shortness of Breath		
How Many Blocks can you Walk Without Shortness of Breath?		
Pacemaker/AICD (Defib)		
Angioplasty or Stent		
Bleeding Tendencies		
Jaundice/Hepatitis		
Acid Reflux/GERD		
Back or Neck Pain/Sciatica		
Arthritis		
Weakness/Numbness in Arms or Legs		
Disabling accident or Fall		
Epilepsy/Convulsions		
Stroke/CVA		
Paralysis/Polio		
Thyroid Disease		
Diabetes		
Kidney Disease		
Drink Alcoholic Beverages		
Recreational Drugs		
Blood Transfusions		
Denture/Caps/Loose Teeth		
Dental Bonding/Laminates		
Motion Sickness/Vertigo		
Could You be Pregnant		
Last Menstrual Period Date		
Unusual Reaction to Anesthesia in Past		

Please List Any Allergies/Unusual Reactions to Medications

Please List All Medications and/or Supplements

[ ] NONE

Drug/Medication Name	Dose	Fequency

Please List Any Previous Surgeries

[ ] NONE

Malignant Hyperthermia Screening

Do you have a family history of unexplained death following General Anesthesia?
☐ Yes ☐ No

Do you have a personal or family history of malignant hyperthermia?
☐ Yes ☐ No

Do you have a muscle or neuromuscular disorder?
☐ Yes ☐ No

Do you have high temperatures following exercise?
☐ Yes ☐ No

Do you have a personal history of muscle spasm, dark or chocolate colored urine, or unanticipated fever immediately following anesthesia or serious exercise?
☐ Yes ☐ No

Internist/Family Doctor Name

rev 3-23-17

Anesthesiologist Signature | Date

Patient Signature | Date

Additional Comments: