PRE-ANESTHESIA QUESTIONNAIRE

Ramapo Valley Surgical Center

Name		
Physician/Surgeon		*Label*
Age	**Height** / **Weight**	

	YES	NO	Please List Any Allergies/Unusual Reactions to Medications
Please Mark All Boxes			
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 All Medications and/or Supplements

[ ] NONE

Drug/Medication Name	Dose	Frequency

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: