ANESTHESIA SPECIALISTS OF HOUSTON, L.L.P.

(If completed on line, please print this document and bring with you at the time of your anesthesia interview to the 2nd floor at the Women Hospital of Texas)

Medical Questionnaire

PATIENT NAME: ____

DATE: ___________ TIME: ___________

Scheduled for :	HT:	WT:

ALLERGIES:	
❑ NO KNOWN DRUG ALLERGIES	
Name of Drug/Food/ or Substance:	Describe your reaction:

GENERAL HISTORY & HABITS				
	Never	Past Date Stopped	Current	Number of Years, and amount per day
TOBACCO				
ALCOHOL				
HABIT FORMING DRUGS				
PHENTERMINE OR OTHER PRESCRIPTION DIET PILLS				

HEALTH HISTORY: PLEASE CHECK ALL THAT APPLY.

HEAD/EYES/EARS:

- ❑ Hearing Loss; R____ L____
- ❑ Hearing Aid; R____ L_____
- ❑ Vision Loss; Glasses_____ Contacts_____
- ❑ Glaucoma
- ❑ Cataract Surgery/ Lens Implant; R_____ L_____
- ❑ Macular Degeneration
- ❑ Nose Bleeds; Last_______
- ❑ Please mark all that apply: ☐Dentures, ☐Partials ☐Bridges ☐Caps ☐Crowns ☐Veneers ☐Broken ☐Loose ☐Missing teeth.
- ❑ Other: ________________________

❑ **NO PROBLEMS**

CARDIOCASCULAR:

- ❑ High Blood Pressure
- ❑ Heart Attack; Date: _______
- ❑ Chest Pain/ Angina
- ❑ Pacemaker/ Defibrillator; Last Interrogation: ____________
- ❑ Irregular Heart Rate
- ❑ Heart Murmur
- ❑ Mitral Valve Prolapse
- ❑ Deep Vein Thrombosis/ Blood Clots; Date: ___________
- ❑ Congestive Heart Failure
- ❑ History of any Cardiovascular Surgery (This includes any surgery performed on Heart, Arteries or Veins)
- ❑ Other: ____________________

❑ **NO PROBLEMS**

ENDOCRINE/OTHER:

- ❑ Diabetes; Insulin Dependent______ Oral Meds_______ Diet Controlled_________
- ❑ Glucose Monitored Daily
- ❑ Hypoglycemia
- ❑ Thyroid Disease
- ❑ Adrenal Disease
- ❑ History of Cancer; Type: _____ Last Chemo: _____ Last Radiation: _____________
- ❑ Blood Disorders/ Blood Clotting Disorders
- ❑ Bleeding/ Anemia
- ❑ Immune Disorders/ HIV
- ❑ Shingles; Last Outbreak: ____
- ❑ Multiple Sclerosis
- ❑ Blood Transfusion; Date: _____ Reaction: _______
- ❑ Other: _____________

❑ **NO PROBLEMS**

NEUROLOGICAL:

- ❑ Migraine Headaches
- ❑ History of Seizures; Last Seizure: _________
- ❑ Weakness; Where: _____
- ❑ Numbness; Where: _____
- ❑ History of Stroke, Date: _____ Residual Problems: _________
- ❑ History of TIA's; Date: _______ Residual Problems: _______
- ❑ Back Pain
- ❑ Neuropathy
- ❑ Other: _____________________

❑ **NO PROBLEMS**

GASTROINTESTINAL:

- ❑ Chronic Nausea and Vomiting
- ❑ Heartburn/ Indigestion
- ❑ Acid Reflux
- ❑ GERD
- ❑ Barrett's Esophagus
- ❑ Hiatal Hernia
- ❑ Gastric Ulcer in the past year
- ❑ Liver Disease
- ❑ Hepatitis B; Treated: ______
- ❑ Hepatitis C; Treated _______
- ❑ Other: _______________

❑ **NO PROBLEMS**

GENITOURINARY:

- ❑ Difficult or Painful Urination
- ❑ Recent Urinary Tract Infection
- ❑ Kidney Disease
- ❑ Dialysis_______________________
- ❑ Are you Pregnant? Yes___ No___ How many weeks? ____________
- ❑ Last Menstrual Period: _________
- ❑ Other: _______________________

❑ **NO PROBLEMS**

RESPIRATORY:

- ❑ Shortness of breath with daily activities.
- ❑ Shortness of breath that is worse at night.
- ❑ Cold or Sore Throat in the last two weeks.
- ❑ Asthma
- ❑ Bronchitis in the last year.
- ❑ Oxygen needed at home. Flow rate: ___________
- ❑ Tuberculosis
- ❑ Chronic Lung Disease
- ❑ COPD
- ❑ Sleep Apnea; Sleep Study

MUSKULOSKETAL/ SKIN:

- ❑ Chronic Rashes
- ❑ Wounds that are non-healing; Where: _________
- ❑ Arthritis
- ❑ Gout
- ❑ Fibromyalgia
- ❑ Limited Mobility; Where: ________

Describe:_______________

____

PROSTHESIS/ ASSISTIVE DEVICES:

- ❑ Artificial or transplanted Valves; _____________________
- ❑ Artificial Joints; Where: ____________________________
- ❑ Limb Prosthesis_______________
- ❑ Implants; Where: ______________
- ❑ Cane needed for walking
- ❑ Walker needed for walking
- ❑ Wheelchair needed for mobility
- ❑ Other: _______________________

Results: ☐Mild ☐Mod ☐Severe ❑ CPAP; Setting: _____ ❑ Severe Snoring ❑ Other: ___________ ❑ **NO PROBLEMS**	________________________ ❑ Spinal Injury Date: ___________ ❑ Other: ___________ ❑ **NO PROBLEMS**	❑ **NO PROBLEMS**

PLEASE LIST ALL SURGERIES STARTING WITH MOST RECENT	
	DATE

MEDICATION LIST:

Name: of Medication, Vitamins, and Supplements	Number: Of Pills, Puffs, or mls	Strength: Mgs, units, or mcgs	Route Taken: Oral, suppository Topical or inhaled	How Often: 1x Daily 2x Daily every 4 hrs, or as needed	Reason for taking this medicine: High Blood Pressure, Diabetes, etc.	Time of day that you normally take this medication?

Please use this sheet for any additional information: