TMH1753

PRE-ADMISSION TESTING (PAT)
ANESTHESIA HEALTH QUESTIONNAIRE

This form is designed to assist your Anesthesiologist and Anesthesia Provider(s) in providing you with the safest care possible during your surgical procedure. **All information is important to the management of your care, so please fill out the entire questionnaire.** If you have any questions or need assistance filling out the questionnaire, please let one of the PAT staff members know and they will assist you as soon as possible.

NAME: _____ **DOB:** _____ **AGE:** _____
GENDER: _____ **HT.** _____ **WT.** _____ **SURGEON:** _____
SURGICAL PROCEDURE: _____ **DATE OF PLANNED SURGERY:** _____
CURRENT PAIN LEVEL (0-10, 0=NO PAIN, 10=WORST PAIN): _____ **LOCATION OF PAIN:** _____
DO YOU HAVE ADVANCED DIRECTIVES AND/OR MEDICAL POWER OF ATTORNEY? ☐ **YES** ☐ **NO**

ALLERGIES: ☐ No Known Drug Allergies (NKDA)

_____
_____
_____

MEDICATIONS (PRESCRIBED, OVER THE COUNTER, SUPPLEMENTS): ☐ I do not take any medications

DRUG NAME:	**DOSAGE:**	**FREQUENCY:**

ANESTHESIA HISTORY:

☐ Malignant Hyperthermia (Yourself or Blood Relative)	☐ Severe TMJ
☐ Difficult Airway	☐ Blood Relative with Major Complication
☐ Awareness while under Anesthesia	☐ Post Op Nausea and/or Vomiting
☐ Difficulty Waking Up after Anesthesia	☐ Other: _____
☐ Difficulty with Movement in Neck	

SURGICAL HISTORY (Procedure and Date):

_____
_____
_____
_____
_____

PHYSICIANS CARING FOR YOU:

Primary Care Physician: _____ Phone: _____ Last Visit: _____
Cardiologist: _____ Phone: _____ Last Visit: _____
Pulmonologist: _____ Phone: _____ Last Visit: _____
Other: _____ Phone: _____ Last Visit: _____

ADHERE PATIENT LABEL WITHIN THIS AREA

HOUSTON Methodist LEADING MEDICINE

CARDIAC HISTORY:

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Coronary Artery Disease/Heart Disease
- ☐ Aortic Valve Stenosis/Regurgitation
- ☐ Mitral Valve Prolapse
- ☐ Atrial Fibrillation/Arrhythmia/Irregular Heart Beat
- ☐ Heart Attack/Myocardial Infarction
- ☐ Cardiac Stent/Heart Stent
- ☐ Chest Pain
- ☐ Congestive Heart Failure
- ☐ Fainting/Syncopal Episode
- ☐ Peripheral Vascular/Artery Disease
- ☐ Pacemaker/Defibrillator (AICD)
- ☐ Left Ventricular Assist Device (LVAD)
- ☐ Heart Transplant

Other: _____

Recent Cardiac Testing: ☐ EKG ☐ Echocardiogram ☐ Stress Test ☐ Cardiac Catheterization

Are you able to climb two flights of stairs without stopping? ☐ YES ☐ NO

If you answered NO to the above question, please explain: _____

Do you exercise regularly? ☐ YES ☐ NO Days per week: _____ Duration: _____

RESPIRATORY/PULMONARY HISTORY:

- ☐ Asthma
- ☐ COPD/Emphysema
- ☐ Shortness of Breath
- ☐ Obstructive Sleep Apnea/Sleep Apnea
- ☐ Uses CPAP/BiPAP
- ☐ Loud Snoring
- ☐ Recent Cold/Sore Throat (last 2 weeks)
- ☐ Home Oxygen Use _____ L/min
- ☐ History of Tracheostomy
- ☐ Lung Transplant
- ☐ Pulmonary Function Test Date: _____
- ☐ Other: _____

NEUROLOGICAL/MENTAL HEALTH HISTORY:

- ☐ Stroke/TIA
- ☐ Seizure Disorders
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Myasthenia Gravis
- ☐ Claustrophobia
- ☐ Muscular Dystrophy
- ☐ Polio/Post-Polio Syndrome
- ☐ Depression/Anxiety
- ☐ Bipolar Disorder
- ☐ Motion Sickness
- ☐ Other: _____

GASTROINTESTINAL/LIVER DISEASE HISTORY/INFECTIOUS DISEASE:

- ☐ GERD
- ☐ Hepatitis Type: _____
- ☐ Cirrhosis
- ☐ HIV
- ☐ Gastric Weight Loss Surgery
- ☐ Difficulty in Swallowing
- ☐ Liver Transplant
- ☐ Other: _____

RENAL/KIDNEY DISEASE HISTORY:

- ☐ Chronic Kidney Disease (CKD)
- ☐ Renal/Kidney Failure/End Stage Renal Disease
- ☐ Kidney Transplant
- ☐ Chronic Urinary Tract Infections
- ☐ Enlarged Prostate/Benign Prostate Hyperplasia

Other Kidney Disease: _____

Are you currently on Dialysis? ☐ Yes ☐ No

Type of Dialysis: ☐ Hemodialysis ☐ Peritoneal **Date of Last Dialysis:** _____

ADHERE PATIENT LABEL WITHIN THIS AREA

BLOOD/CLOTTING DISORDER HISTORY:

☐ Anemia
☐ Received Blood Transfusion in last 3 months?
☐ Blood Clot in Extremities or Lungs (DVT/PE)
☐ Bleeding or Clotting Disorder
☐ Cancer Type: _____
☐ Treated with Chemo ☐ Treated with Radiation
☐ Sickle Cell Disease/Trait
☐ Other: _____

ENDOCRINE DISEASE HISTORY:

☐ Diabetes ☐ Type I ☐ Type II
☐ Hypothyroidism
☐ Hyperthyroidism
☐ Steroid/Prednisone Use Last Dose: _____
☐ Recent hospitalization due to high or low blood sugar
☐ Other: _____

ARTHRITIS, SPINE, JOINT OR CONNECTIVE TISSUE DISEASE:

☐ Rheumatoid Arthritis
☐ Degenerative Arthritis
☐ Ankylosing Spondylitis
☐ Spine Problems ☐ neck ☐ upper back ☐ lower back
☐ Scleroderma
☐ Other: _____

FOR WOMEN:

Date of Last Menstrual Period (LMP): _____
Are you currently Pregnant? ☐ YES ☐ NO ☐ UNSURE
Obstetrician: _____
☐ Not Menstruating Reason: _____
If YES, how many weeks? _____
Currently Breastfeeding? ☐ YES ☐ NO

OTHER MEDICAL HISTORY:

☐ Hearing Loss
☐ Vision Loss/Blindness
☐ Glaucoma
☐ Loose Teeth
☐ Dental Bridge
☐ Dentures
☐ Capped Teeth
☐ Skin Condition
☐ Hearing Aids
☐ Contact Lenses
☐ Tongue/Body Piercing
☐ Other: _____

- **Have you been to the Emergency Room or Hospitalized in the last 12 months? ☐ YES NO**

If you answered YES to the above, please explain why:

_____

Have you ever used Tobacco, Alcohol, or Illicit Drugs?

☐ Cigarette Smoking _____ Packs per Day _____ Years of Smoking If quit, what year? _____
☐ Cigar or Pipe Smoking _____ Quantity per Day _____ Years of Smoking If quit, what year? _____
☐ Smokeless Tobacco _____ Quantity per Day _____ Years of Use If quit, what year? _____
☐ Alcohol _____ Drinks per Week Have you been treated for alcoholism in the past? ☐ YES ☐ NO
☐ Marijuana Use ☐ Cocaine Use ☐ Methamphetamine Use ☐ Other "Street" Drug(s): _____
Have you been treated for drug addiction in the past? ☐ YES ☐ NO

Any other medical conditions or concerns about **ANESTHESIA**, you wish to inform Anesthesiologist?

_____

_____

You will meet with your Anesthesiologist on the day of surgery and the risks and benefits associated with Anesthesia will be discussed at that time.

I have read and answered all questions truthfully. _____
SIGNATURE DATE/TIME

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

PAT PATIENT QUESTIONNAIRE

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