# The Kissimmee FL Endoscopy ASC, LLC

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## ANESTHESIA QUESTIONNAIRE - ADULTS

*Please answer each question prior to your procedure. This will assist the Anesthesia Department in making your pre-anesthesia evaluation.*

1. Please list any major illnesses you have had in your life. _____

2. Please list any medication that you take and their doses. _____

| CHECK YES OR NO | YES | NO |
|---|---|---|
| 3. Have you taken prednisone, steroids, or ACTH in the past six months? | ☐ | ☐ |
| 4. Are you allergic to any medications: If yes, what? _____ | ☐ | ☐ |
| What happens? _____ | | |
| | ☐ | ☐ |
| 5. Have you ever had high or low blood pressure? | ☐ | ☐ |
| 6. Have you ever had trouble with your heart? | ☐ | ☐ |
| 7. Have you ever had a heart attack? If yes, when? _____ | ☐ | ☐ |
| 8. Do you have angina chest pains? If yes, how often? _____ | ☐ | ☐ |
| 9. Do you have any trouble with your breathing or lungs? | | |
| (circle) Asthma Wheezing Emphysema Cough up anything | ☐ | ☐ |
| 10. Do you smoke? If yes, how much? _____ | ☐ | ☐ |
| 11. Have you had a cold or flu in the past two weeks? | ☐ | ☐ |
| 12. Does anyone in the family have a cold or flu? | ☐ | ☐ |
| 13. Do you have any problems with your breathing while lying flat? | ☐ | ☐ |
| 14. Have you ever had a stroke? If yes, when? _____ | ☐ | ☐ |
| 15. Have you ever had dizziness, fainting spells, seizures, or epilepsy? | ☐ | ☐ |
| 16. Do you have any part of your body that is numb or weak? | ☐ | ☐ |
| 17. Have you ever had any problems with your liver or kidneys? | ☐ | ☐ |
| 18. Have you ever had hepatitis or yellow jaundice? If yes, when? _____ | ☐ | ☐ |
| 19. Do you have problems with swallowing, heartburn, indigestion, hiatal hernia, or vomiting? | ☐ | ☐ |
| 20. Do you have diabetes? If yes, how long? _____ | ☐ | ☐ |
| 21. Do you have arthritis? If yes, where? _____ | ☐ | ☐ |
| 22. Have you ever had problems with bleeding or easy bruising? | ☐ | ☐ |
| 23. Have you ever had a transfusion? If yes, when? _____ | ☐ | ☐ |
| 24. Do you wear contact lenses? If yes, please remove before surgery | | |
| 25. Do you have (circle) dentures caps bridges loose teeth? | | |
| 26. Please list any operations you have had and their dates _____ | ☐ | ☐ |
| _____ | ☐ | ☐ |
| _____ | ☐ | ☐ |
| 27. Have you ever had any problems with general anesthetic? If yes, what? _____ | ☐ | ☐ |
| 28. Have you ever had any problems with spinal anesthetic? | ☐ | ☐ |
| 29. Have any relatives had any problems with anesthetics (high fevers, breathing troubles, etc.)? | | |
| 30. How many drinks or beers do you have in an average day? _____ Week? _____ | | |
| 31. Is there any chance that you are pregnant? | ☐ | ☐ |
| 32. Date of your last menstrual period _____ | | |
| 33. Height _____ Weight _____ | | |
| 34. Do you have any questions? | | |

Patient signature _____ Date _____