INDIO SURGERY CENTER
OUTPATIENT SCREENING
PRE-ANESTHESIA QUESTIONNAIRE

Please read and fill out carefully. All information is confidential. Your anesthesiologist will use this information to help plan the anesthesia.

1. Please state your: AGE_____ HEIGHT_____ WEIGHT_____ SEX_____
2. Primary Language:_____ Interpreter Needed? ☐ Yes ☐ No
3. Have you ever had an illness such as the following?

Year		Year		Year	
☐	ASTHMA	☐	HEPATITIS	☐	BLEEDING DISORDER
☐	CHRONIC BRONCHITIS	☐	JAUNDICE	☐	SICKLE CELL DISORDER
☐	EMPHYSEMA	☐	KIDNEY DIS.	☐	HEMOPHILLIA
☐	TUBERCULOSIS	☐	SEIZURES	☐	EASY BRUSING
☐	HIGH BLOOD PRESSURE	☐	EPILEPSY	☐	MUSCLE DIS.
☐	DIABETES	☐	STROKE	☐	ARTHRITIS
☐	THYROID DISEASE	☐	OTHER_____		

4. Have you ever had a heart attack, heart irregularity, or palpitations? ☐ Yes ☐ No
   Do you get shortness of breath with light work? ☐ Yes ☐ No
   Do you awaken from sleep because you can't breath? ☐ Yes ☐ No
   Do you sleep with two or more pillows to be able to breath? ☐ Yes ☐ No
5. Are you wearing contact lenses, dentures, partial plates, capped teeth or do you have loose teeth? ☐ Yes ☐ No
6. Have you ever had minor or major surgeries before? ☐ Yes ☐ No
   Please list procedures and year_____
7. If you have had surgery before, did you have any anesthesia problems such as high fever (Malignant Hyperthermia), prolonged muscle weakness, or breathing problems? ☐ Yes ☐ No
   Please explain:_____
8. Are you taking any medications? (Aspirin & herbal products included)? ☐ Yes ☐ No
   Please list: NAME, DOSE, FREQUENCY_____
9. Are you ALLERGIC to any medications? ☐ Yes ☐ No
   Please list:_____
10. Do you smoke? ☐ Yes ☐ No # of pack a day_____, #Years_____, #Years quit_____
11. Have you had a cough or fever in the past three days? ☐ Yes ☐ No
12. If you are a woman, is there a possibility you are pregnant? ☐ Yes ☐ No
13. Do you have any pain at this time? ☐ Yes ☐ No What level of pain do you have?_____
14. Who is your ride home?_____
    (Name) (Phone #)

Comments:_____

_____
Patient/Parent/Caregiver Signature Date

INDIO SURGERY CENTER

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PATIENT INFORMATION

Patient Sticker

Form ISC 010/ rvsd 01/07