SFGH Anesthesia Preop Clinic

...your trusted source of information

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MRN:

Name:

DOB:

Patient questionnaire (adult)

/		%

Your weight and height:

lbs	feet/inches

Question	Answer
Do you ever have any **pain or discomfort in your chest**?	Yes / No
Have you ever had a **severe pain or pressure across the front of your chest** lasting for half an hour or more?	Yes / No
Do you have **swelling in your feet or ankles** at times?	Yes / No
Are you troubled by **shortness of breath** when:	
Walking **on the level**?	Yes / No
Walking up **a slight hill**?	Yes / No
Sleeping **at night**?	Yes / No
How many flights of stairs can you climb without stopping?	______
Do you sometimes get **pains in the calves** of your legs when you walk?	Yes / No
Does your chest ever sound **wheezy or whistling**?	Yes / No
Have you been told that you **snore, choke or gasp** most nights while sleeping?	Yes / No
Have you had a **cold, bronchitis or other respiratory infection** within the last two weeks?	Yes / No
Do you **usually have a cough**?	Yes / No
Do you or does anyone in your family have **serious bleeding problems** such as prolonged bleeding following surgeries or cuts?	Yes / No
Have you taken any **aspirin, other blood thinners, or arthritis medicine** in the last two weeks?	Yes / No
Have you ever had **problems with anemia** or been told to take iron pills?	Yes / No
Have you had any **abnormal blood loss** such as black, tarry or bloody stools, abnormal vaginal bleeding?	Yes / No
Have you or any of your relatives ever had **problems with anesthesia**?	Yes / No
Is there any chance that you **may be pregnant**?	Yes / No

Do you currently smoke?

Yes	How many? For how long?
No, but I have in the past	For how long did you smoke? When did you quit?
No	

Do you drink alcohol?

Yes	How much? How often?
No, but I have in the past	When did you quit?
No	

Do you use any recreational drugs?

Yes	What types? How much?
No, but I have in the past	When did you quit?
No	

Have you had any surgeries in the past?

Surgery	Year