BETH ISRAEL HEALTH CARE SYSTEM

1375

PATIENT PRE-ANESTHESIA QUESTIONNAIRE

Name of Patient: _____ Age: _____ Weight: _____ Height: _____

Date of Procedure: _____ Procedure: _____ Surgeon: _____

Person to drive you home: _____ Telephone number: _____

Instructions: Please indicate if you have or have had any of the following. If you do not understand any question or are unsure of the answer, place a question mark next to the question.

Are you allergic to any medications?
Please list: _____ ☐ Yes ☐ No

Do you or have you ever smoked?
How much? _____ ☐ Yes ☐ No

Do you or have you used any recreational or "street drugs?"
Describe: _____ ☐ Yes ☐ No

Do you drink alcohol?
How much? _____ ☐ Yes ☐ No

Could you be pregnant? ☐ Yes ☐ No

Have you had a blood transfusion? ☐ Yes ☐ No

Asthma or wheezing? ☐ Yes ☐ No

Any other breathing or lung problems? ☐ Yes ☐ No

High blood pressure? ☐ Yes ☐ No

Heart attack? ☐ Yes ☐ No

Angina or chest pain? ☐ Yes ☐ No

Is pain one of the reasons you are here today? ☐ Yes ☐ No

If yes, where is your pain: _____

How long have you had your pain: _____

Irregular heart beat? ☐ Yes ☐ No

Any other heart problems? ☐ Yes ☐ No

Liver problems or hepatitis? ☐ Yes ☐ No

Kidney problems? ☐ Yes ☐ No

Diabetes or high blood sugar? ☐ Yes ☐ No

Epilepsy or seizures? ☐ Yes ☐ No

Stroke, paralysis, meningitis? ☐ Yes ☐ No

HIV or AIDS? ☐ Yes ☐ No

Blood disease or bleeding problems? ☐ Yes ☐ No

Sickle cell disease? ☐ Yes ☐ No

Have you or a blood relative ever had any problems with an anesthetic? ☐ Yes ☐ No

Can you climb a flight of stairs quickly or walk 4 miles in an hour? ☐ Yes ☐ No

Rate your pain by circling the face that best describes it:

WONG/BAKER FACES PAIN SCALE

From Wong DL, Hockenberry-Eaton M, Wilson D, Winkelstein ML, Schwartz P: :Wong's Essentials of Pediatric Nursing, ed. 6, St. Louis, 2001, p. 1301.
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List any medicines, inhalers, pain medications, over the counter drugs, dietary supplements or herbal preparations you currently take or have taken in the last six months: _____

List any operations you have had, along with the date of each: _____

Additional comments or concerns not covered above: _____

_____ _____ _____
Signature of patient or person completing form Date Time

_____ _____ _____
Reviewed by Anesthesiologist/P.A . Date Time

ACKNOWLEDGEMENT OF NEED FOR ESCORT AT TIME OF DISCHARGE FROM AMBULATORY SURGERY UNIT

I, _____, ACKNOWLEDGE THAT I HAVE BEEN INFORMED IN ADVANCE, OF MY APPOINTMENT FOR AMBULATORY SURGERY, THAT ANOTHER ADULT MUST ESCORT ME HOME AT THE TIME OF DISCHARGE. I UNDERSTAND THAT I WILL BE DISCHARGED ONCE I HAVE RECOVERED SUFFICIENTLY FROM ANESTHESIA AND SURGERY TO TRAVEL, BUT THAT I HAVE A RESPONSIBLE ADULT TO ESCORT ME HOME.
THIS PRECAUTION IS NECESSARY BECAUSE OCCASIONALLY PATIENTS EXPERIENCE PROBLEMS EVEN THOUGH THEY HAVE BEEN MEDICALLY STABLE PRIOR TO DISCHARGE. ACCORDINGLY, I HAVE MADE, OR WILL MAKE, ARRANGEMENTS FOR ANOTHER ADULT TO ESCORT ME WHEN I AM DISCHARGED FROM THE AMBULATORY SURGERY UNIT.

SIGNED: _____**(PATIENT)**

DATE: _____ **TIME:** _____

SIGNED: _____**(WITNESS)**

DATE: _____ **TIME:** _____