

**WEST CARVER MEDICAL – A Division of ProHealth Care Associates LLP
MOBILE MEDICAL SERVICES, P.C.
ANESTHESIA QUESTIONNAIRE**

PLEASE RETURN THIS QUESTIONNAIRE THE DAY OF YOUR PROCEDURE

Patient Name:	Date of Birth:	Age:
Height:	Weight:	
Procedure:	Physician:	

Patient History

Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seizure Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Irreg. Heart Beat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mitral Valve Prolapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chronic Obstructive Pulmonary Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gastrointestinal	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Valve Replaced	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sleep Apnea	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Neurologic Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vascular Grafts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Musculoskeletal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bladder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bleeding Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vision/ Hearing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pregnant	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Alcohol (how much)	Tobacco (how much)	Last Menstrual Cycle
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Other Illness/ Diseases:

SURGICAL HISTORY

PRIOR ANESTHESIA DIFFICULTIES

BLOOD RELATIVES WITH ANESTHESIA DIFFICULTIES

ALLERGIES

CURRENT MEDICATIONS	Time of Last Dose	FOR PHYSICIAN USE	
		PHYSICAL EXAM (if not done within last two weeks)	Normal
		Heart	<input type="checkbox"/>
		Lungs	<input type="checkbox"/>
		HEENT	<input type="checkbox"/>
		Abd.	<input type="checkbox"/>
		Other:	<input type="checkbox"/>

Aspirin Date discontinued

Anticoagulants Date discontinued

NSAIDS Date discontinued

MD Signature: _____ **Date:** _____