

**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

Year	Year	Year
_____ ASTHMA	_____ HEPATITIS	_____ BLEEDING ISORDER
_____ CHRONIC BRONCHITIS	_____ JAUNDICE	_____ SICKLE CELL DISORDER
_____ EMPHYSEMA	_____ KIDNEY DIS.	_____ HEMOPHILIA
_____ TUBERCULOSIS	_____ SEIZURES	_____ EASY BRUISING
_____ 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 breathe? 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 procedure 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 products included) Yes No  
 Please list: NAME, DOSE, FREQUENCY \_\_\_\_\_

9. Are you allergic to any medications?  
 Please list: \_\_\_\_\_

10. Do you smoke? Yes No # packs a day, # years, # years quit  
 11. Have you had a cough or fever in the last 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?  
 What level of pain do you have? \_\_\_\_\_  
 14. Who is your ride home? \_\_\_\_\_

(Name)

(Phone#)

COMMENTS \_\_\_\_\_

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PATIENT INFORMATION**

Patient /Parent/Caregiver Signature Date

Patient Sticker