

Straith Clinic, P.C.
Health Questionnaire/Pre-Anesthesia Evaluation

Name: _____ Age: _____ Male ___ Female ___
 Height _____ Weight _____ BMI _____ (RN use only)
 Family Doctor: Name _____ City: _____ Phone (____) _____
 Emergency contact: Name: _____ Phone (____) _____

Pre-Operative Health History

	yes	no		yes	no
chronic cough or lung problems	___	___	hepatitis (A, B, or C ? _____)	___	___
shortness of breath at rest	___	___	kidney disorder	___	___
shortness of breath with exercise	___	___	thyroid disease	___	___
recent cold/bronchitis/pneumonia	___	___	stomach ulcer	___	___
history of asthma or wheezing	___	___	chronic heartburn/gastric reflux/hiatal hernia	___	___
history of emphysema	___	___	could you be pregnant?	___	___
history of tuberculosis	___	___	last menstrual period/date _____	___	___
history of sleep apnea/CPAP	___	___	dentures/bridges/caps	___	___
history of snoring	___	___	skin problems	___	___
high blood pressure	___	___	circulation problems/swelling of ankles	___	___
for how many years? _____	___	___	blood clots	___	___
heart attack; date _____	___	___	hard of hearing	___	___
heart failure; date _____	___	___	wear glasses/contact lenses	___	___
irregular heart beat; date _____	___	___	problems walking	___	___
chest discomfort/tightness with exercise/ angina	___	___	chemotherapy	___	___
mitral valve prolapse	___	___	compromised immune system/AIDS/HIV	___	___
heart murmur	___	___	history of motion sickness	___	___
stroke	___	___	problems with chewing/swallowing	___	___
TIA	___	___	emotional problems	___	___
Multiple Sclerosis	___	___	what ? _____	___	___
weakness/paralysis	___	___	when ? _____	___	___
epilepsy/seizures	___	___	substance abuse	___	___
date of last seizure _____	___	___	what ? _____	___	___
chronic back problems	___	___	when ? _____	___	___
excessive bleeding from surgery	___	___	addictive drugs	___	___
history of anemia (low blood count)	___	___	what ? _____	___	___
diabetes (type I or II ? _____)	___	___	when ? _____	___	___
since _____	___	___	alcoholic drinks (____ per week)	___	___
hypoglycemia	___	___	smoking	___	___
liver disease/jaundice	___	___	____ packs per day for ____ years	___	___
			date stopped smoking _____		

Have you had:

	yes	no	if yes, when/where/doctor's name
an exam by a cardiologist	___	___	_____
heart catheterization	___	___	_____
exercise stress test	___	___	_____
ultrasound of heart (echocardiogram)	___	___	_____
pacemaker	___	___	_____

Please list all previous hospitalizations (including surgery, childbirth, medical illness, bariatric)

date (approx year)	reason	place (hospital or city)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

