



# Cleveland Nasal Sinus & Sleep Cer

Howard L. Levine, M.D., F.A.C.S

## PREANESTHETIC QUESTIONNAIRE

This questionnaire is designed to assist the staff who will be taking care of you. It will help us to learn more about your health. Please fill it out as completely as possible and return it to the reception desk.

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Occupation: \_\_\_\_\_

Please leave the number you can be reached the night before surgery: \_\_\_\_\_

Referring Surgeon: \_\_\_\_\_ Type of operation: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_

Have you been a patient in this pre-operative anesthesia clinic in the past 3 months?  Yes  No

What kind of physical exercise do you do? (i.e., walk, run, bike, etc. or none) \_\_\_\_\_

### Previous Surgery:

Year of Surgery	Type of Operation	General or Local (were you put to sleep?)	Problem(s) Complications	Explain
1. _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
2. _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
3. _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
4. _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Have you ever been hospitalized for an illness not requiring surgery:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Do you **have** or **have you ever** had any of these problems: (Please circle)

- |                                |   |  |
|--------------------------------|---|--|
| 1. Heart problems of any kind  | 7. Bleeding problem                                   | 13. Blood transfusion                              |
| 2. Stroke                      | 8. Cancer   | 14. Tuberculosis (TB)                              |
| 3. Kidney or bladder problems  | 9. Seizure or epilepsy                                | 15. Thyroid disease (or problems)                  |
| 4. Liver problems or hepatitis | 10. Rheumatic fever                                   | 16. Gastroesophageal Reflux disease/ Hiatal hernia |
| 5. High blood pressure         | 11. Rheumatoid arthritis                              | 17. Sleep Anea                                     |
| 6. Diabetes                    | 12. Lung problem (e.g., pneumonia, emphysema, asthma) | 18. Date of last menstrual period                  |
|                                |   | 19. Other: _____                                   |

Please name any medicines that you are presently taking; include **all** prescription and non-prescription drugs (even aspirin):

Name of medication	Dosage (amount)	Number of times taken each day
1. _____		
2. _____		

3. \_\_\_\_\_  
Are you allergic to, or have you had unusual reactions to medications, adhesive tape, foods or latex? Please list the items and the type of reaction you experienced.

\_\_\_\_\_  
\_\_\_\_\_

Have you taken steroids such as prednisone or cortisone?  Yes  No

If so, when? \_\_\_\_\_

Do you have any of the following: (Please circle)

false teeth, capped teeth, loose teeth, braces, chipped teeth

or teeth that need dental care, specify \_\_\_\_\_

Have you or any of your close relatives had problems or complications with anesthesia?  Yes  No

If so, what? \_\_\_\_\_

Did your doctor ask you to donate your own blood for surgery?  Yes  No How many units? \_\_\_\_\_

At the present time, do you have? (Please check appropriate boxes)

- chest pain
- blackouts or periods of dizziness
- palpitations or irregular heart beats
- pain in your legs with exercise
- ankle swelling
- shortness of breath at night
- shortness of breath while walking up one flight of stairs
- chronic cough or sputum (phlegm)
- blood in your sputum
- black or tarry stools, diarrhea
- frequent nausea and vomiting
- temporary loss or blurring of vision
- temporary weakness of one or more limbs
- facial weakness, numbness
- burning with urination or frequent urination
- arthritis or severe joint pains
- back pain or neck pain
- excessive bleeding following minor cuts or dental surgery
- recent weight loss
- difficulty walking
- pregnancy
- acid reflex symptoms
- heart murmur

Have you had any problems in the last two weeks with: (Please circle)

A "cold," "flu," bronchitis, laryngitis, sore throat, fever

Have you ever smoked?  Yes  No If yes, at worst, how many packs per day? \_\_\_\_\_

How many years? \_\_\_\_\_ If you quit, when? \_\_\_\_\_

Do you drink alcoholic beverages?  Yes  No How often? \_\_\_\_\_ How much? \_\_\_\_\_

Do you use "recreational" or illegal drugs?  Yes  No Type \_\_\_\_\_

**Questions for anesthesiologist:**

1. \_\_\_\_\_

2. \_\_\_\_\_



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