HOUSTON Methodist LEADING MEDICINE

ANESTHESIA PREOPERATIVE EVALUATION CLINIC (APEC)
ANESTHESIA HEALTH QUESTIONNAIRE

This form is designed to assist your Anesthesiologist and Anesthesia Provider(s) in providing you with the safest care possible during your surgical procedure. ***All information is important to the management of your care, so please fill out the entire questionnaire.*** *If you have any questions or need assistance filling out the questionnaire, please let one of the APEC staff members know and they will assist you as soon as possible.*

NAME: ______________________ **DOB:** ____________ **AGE:** ________
GENDER: __________ **HT.** ______ **WT.** _______ **SURGEON:** ______________________
SURGICAL PROCEDURE: ______________________ **DATE OF PLANNED SURGERY:** ______________
CURRENT PAIN LEVEL (0-10, 0=NO PAIN, 10=WORST PAIN): _______ **LOCATION OF PAIN:** ______________
DO YOU HAVE ADVANCED DIRECTIVES AND/OR MEDICAL POWER OF ATTORNEY? ☐ **YES** ☐ **NO**

ALLERGIES: ☐ No Known Drug Allergies (NKDA)
____
____
____

MEDICATIONS (PRESCRIBED, OVER THE COUNTER, SUPPLEMENTS): ☐ I do not take any medications
DRUG NAME: **DOSAGE:** **FREQUENCY:**
____
____
____
____
____
____
____
____

ANESTHESIA HISTORY:

- ☐ Malignant Hyperthermia (Yourself or Blood Relative)
- ☐ Difficult Airway
- ☐ Awareness while under Anesthesia
- ☐ Difficulty Waking Up after Anesthesia
- ☐ Difficulty with Movement in Neck
- ☐ Severe TMJ
- ☐ Blood Relative with Major Complication
- ☐ Post Op Nausea and/or Vomiting
- ☐ Other: ______________________

SURGICAL HISTORY (Procedure and Date):
____
____
____
____
____
____

PHYSICIANS CARING FOR YOU:
Primary Care Physician: ______________________ Phone: ____________ Last Visit: __________
Cardiologist: ______________________ Phone: ____________ Last Visit: __________
Pulmonologist: ______________________ Phone: ____________ Last Visit: __________
Other: ______________________ Phone: ____________ Last Visit: __________

HOUSTON Methodist LEADING MEDICINE

ANESTHESIA PREOPERATIVE EVALUATION CLINIC (APEC)
ANESTHESIA HEALTH QUESTIONNAIRE

CARDIAC HISTORY:

☐ High Blood Pressure
☐ High Cholesterol
☐ Coronary Artery Disease/Heart Disease
☐ Aortic Valve Stenosis/Regurgitation
☐ Mitral Valve Prolapse
☐ Atrial Fibrillation/Arrhythmia/Irregular Heart Beat
☐ Heart Attack/Myocardial Infarction
☐ Cardiac Stent/Heart Stent
☐ Chest Pain
☐ Congestive Heart Failure
☐ Fainting/Syncopal Episode
☐ Peripheral Vascular/Artery Disease
☐ Pacemaker/Defibrillator (AICD)
☐ Left Ventricular Assist Device (LVAD)
☐ Heart Transplant
Other: ____________________________________

Recent Cardiac Testing: ☐ EKG ☐ Echocardiogram ☐ Stress Test ☐ Cardiac Catheterization

Are you able to climb two flights of stairs without stopping? ☐ YES ☐ NO

If you answered NO to the above question, please explain: ____

Do you exercise regularly? ☐ YES ☐ NO Days per week: ____________ Duration: ______________

RESPIRATORY/PULMONARY HISTORY:

☐ Asthma
☐ COPD/Emphysema
☐ Shortness of Breath
☐ Obstructive Sleep Apnea/Sleep Apnea
☐ Uses CPAP/BiPAP
☐ Loud Snoring
☐ Recent Cold/Sore Throat (last 2 weeks)
☐ Home Oxygen Use _______ L/min
☐ History of Tracheostomy
☐ Lung Transplant
☐ Pulmonary Function Test Date: ____________
☐ Other: _____________________________________

NEUROLOGICAL/MENTAL HEALTH HISTORY:

☐ Stroke/TIA
☐ Seizure Disorders
☐ Multiple Sclerosis
☐ Parkinson's Disease
☐ Myasthenia Gravis
☐ Claustrophobia
☐ Muscular Dystrophy
☐ Polio/Post-Polio Syndrome
☐ Depression/Anxiety
☐ Bipolar Disorder
☐ Motion Sickness
☐ Other: _____________________________________

GASTROINTESTINAL/LIVER DISEASE HISTORY/INFECTIOUS DISEASE:

☐ GERD
☐ Hepatitis Type: ______
☐ Cirrhosis
☐ HIV
☐ Gastric Weight Loss Surgery
☐ Difficulty in Swallowing
☐ Liver Transplant
☐ Other: _____________________________________

RENAL/KIDNEY DISEASE HISTORY:

☐ Chronic Kidney Disease (CKD)
☐ Renal/Kidney Failure/End Stage Renal Disease
☐ Kidney Transplant
☐ Chronic Urinary Tract Infections
☐ Enlarged Prostate/Benign Prostate Hyperplasia
Other Kidney Disease: _____________________________

Are you currently on Dialysis? ☐ Yes ☐ No

Type of Dialysis: ☐ Hemodialysis ☐ Peritoneal **Date of Last Dialysis:** _____________________

HOUSTON Methodist LEADING MEDICINE

ANESTHESIA PREOPERATIVE EVALUATION CLINIC (APEC)
ANESTHESIA HEALTH QUESTIONNAIRE

BLOOD/CLOTTING DISORDER HISTORY:

☐ Anemia
☐ Received Blood Transfusion in last 3 months?
☐ Blood Clot in Extremities or Lungs (DVT/PE)
☐ Bleeding or Clotting Disorder
☐ Cancer Type: ___________________________________
☐ Treated with Chemo ☐Treated with Radiation
☐ Sickle Cell Disease/Trait
☐ Other: ____

ENDOCRINE DISEASE HISTORY:

☐ Diabetes ☐ Type I ☐ Type II
☐ Hypothyroidism
☐ Hyperthyroidism
☐ Steroid/Prednisone Use Last Dose: _______________
☐ Recent hospitalization due to high or low blood sugar
☐ Other: ____

ARTHRITIS, SPINE, JOINT OR CONNECTIVE TISSUE DISEASE:

☐ Rheumatoid Arthritis
☐ Degenerative Arthritis
☐ Ankylosing Spondylitis
☐ Spine Problems ☐ neck ☐ upper back ☐ lower back
☐ Scleroderma
☐ Other: ____

FOR WOMEN:

Date of Last Menstrual Period (LMP): __________________ ☐ Not Menstruating Reason: _________________
Are you currently Pregnant? ☐ YES ☐ NO ☐ UNSURE **If YES, how many weeks? ______________________**
Obstetrician: ____ Currently Breastfeeding? ☐ YES ☐ NO

OTHER MEDICAL HISTORY:

☐ Hearing Loss
☐ Vision Loss/Blindness
☐ Glaucoma
☐ Loose Teeth
☐ Dental Bridge
☐ Dentures
☐ Capped Teeth
☐ Skin Condition
☐ Hearing Aids
☐ Contact Lenses
☐ Tongue/Body Piercing
☐ Other: ________________________

- **Have you been to the Emergency Room or Hospitalized in the last 12 months? ☐ YES ☐ NO**
  If you answered YES to the above, please explain why:
  ____

Have you ever used Tobacco, Alcohol, or Illicit Drugs?

☐ Cigarette Smoking _____ Packs per Day ______ Years of Smoking If quit, what year? ________
☐ Cigar or Pipe Smoking ______ Quantity per Day ______ Years of Smoking If quit, what year? ________
☐ Smokeless Tobacco ______ Quantity per Day ______ Years of Use If quit, what year? ________
☐ Alcohol ______ Drinks per Week Have you been treated for alcoholism in the past? ☐ YES ☐ NO
☐ Marijuana Use ☐ Cocaine Use ☐ Methamphetamine Use ☐ Other "Street" Drug(s): _________
Have you been treated for drug addiction in the past? ☐ YES ☐ NO

Any other medical conditions or concerns about **ANESTHESIA**, you wish to inform Anesthesiologist?
____
____

You will meet with your Anesthesiologist on the day of surgery and the risks and benefits associated with Anesthesia will be discussed at that time.

I have read and answered all questions truthfully. ____
SIGNATURE DATE

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other: __________________________